Health Insurance Counseling and Advocacy Program (HICAP)

HICAP
Volunteer Counselor Handbook

Supported by a grant from the California Department of Aging (CDA)

The CDA is not a co-author of this handbook and assumes no liability for any representation or material contained herein.

[This Page Intentionally Blank}

HICAP Volunteer Counselor Handbook
Summary Table of Contents

[This Page Intentionally Blank}

HICAP Volunteer Counselor Handbook
Table of Contents

Preface

The California Department of Aging (CDA) Health Insurance Counseling and Advocacy Program (HICAP) Volunteer Counselor Handbook ('Handbook') is designed to be a desktop reference for California HICAP Counselors, as well as a resource for training new HICAP Counselors.

The passage of the Medicare Modernization Act (MMA) of 2003 has resulted in the most significant change to Medicare since its inception in 1965. Over 4 million Medicare beneficiaries in California are affected by Medicare Part D, the new prescription drug benefit which will be effective in January 2006.

Facing the implementation of the MMA in California poses a substantial challenge to the frontline HICAP counseling projects and dedicated volunteers. It is anticipated that even though the federal government features national toll free numbers for the Social Security Administration and Medicare, individuals will be referred to the local HICAP counseling offices for individualized assistance.

The Handbook is intended to provide a needed resource in light of the passage of the MMA and to serve as a helpful training tool for the HICAP network during this challenging period.

HICAP

HICAP was established in 1984 by legislation (Welfare and Institutions Code, Section 9750-9756, Chapter 1464, Statutes of 1984, AB 2419), and updated in 1996 legislation, (Welfare and Institutions Code, Section 9541, Chapter 1097, Statutes of 1996, AB 288). In 1997, following the passage of the Older Californians Act (AB 2800), the CDA shifted primary administrative responsibility for the HICAP network to 33 Area Agencies on Aging (AAAs), which are now responsible for the delivery of statewide HICAP services.

Before a HICAP Counselor can be registered, he/she must complete 24-hour basic orientation training and a minimum ten-hour internship. The Handbook is intended for use as both the core HICAP training curriculum and as a field reference guide by Counselors.

The Handbook is an operational guideline only, and is not intended to give legal, accounting, management or other professional advice. Although care has been taken to ensure that information in this manual is accurate and up-to-date, it relies upon federal, state and local laws, and resources that are subject to periodic change and amendment. All readers should be aware of such possible changes, and should verify the application of laws, regulations and other information with a responsible agency before acting or relying upon them.

Acknowledgements

The production of the Handbook was made possible through the "HICAP Training Project 2005" grant provided by the California Department of Aging (CDA) to California Health Advocates (CHA). CHA is dedicated to timely and responsive California Medicare beneficiary advocacy and education, and appreciates the opportunity to be part of this important educational effort.

CHA recognizes the expertise of staff David Lipschutz, Staff Attorney and Bonnie Burns, Training & Policy Specialist, without whom this project would not have been possible. In addition and most importantly, CHA thanks the following members of the User Advisory Group (UAG) and our project partners for their hard work, dedication and shared expertise:

User Advisory Group

Connie Corrales, Program Manager
HICAP- Santa Clara County
Silicon Valley Council of Aging

Larry Bodiford, Program Manager
HICAP- Alpine, Amador, Calaveras, Mariposa and Tuolumne
Area 12 Agency on Aging

Joy Parker, Program Manager
HICAP- San Diego and Imperial
Elder Law & Advocacy

Janet Van Deusen, Program Manager
HICAP- Alameda County
Legal Assistance for Seniors

Ross Kaplan, Aging Programs Specialist
HICAP
California Department of Aging

Project Partners

Aileen Harper, Executive Director
HICAP – Los Angeles
Center for Health Care Rights

Janet Van Deusen, Program Manager
HICAP- Alameda County
Legal Assistance for Seniors

[This Page Intentionally Blank}

Chapter 1
Medicare Overview

I. Introduction

Medicare is the nation's health insurance program for people age 65 or older, and for certain people younger than 65 with disabilities. The rules as to who is eligible for Medicare as well as to when a person can sign up for Medicare are explained in this chapter.

With the passage of the Medicare Modernization Act of 2003 (MMA), the Medicare program is undergoing some of its most significant changes since it began in 1965. The law adds prescription drug coverage through Medicare Part D beginning in January 2006, and added new preventive benefits. The MMA also created a temporary prescription drug discount card program that ends in December 2005. In addition, starting in 2006, beneficiaries face new enrollment restrictions with regard to joining, switching, or disenrolling from Medicare Part D and Medicare Advantage (MA) plans (formerly known as "Medicare + Choice" plans). Because of the major changes created by this law, beneficiaries have important choices to make by the end of 2005 and the beginning of 2006, regarding how to receive their Medicare benefits and which plan(s) to enroll in. These choices will affect the health care, services, and benefits they receive.

The original intent of Medicare was to help protect people from becoming impoverished by the cost of some catastrophic event, such as a car accident or heart attack. Thus, Medicare does not cover all health care needs and is not cost-free. Many health care services are not

covered, and Medicare beneficiaries must pay a portion of the cost for services that are covered.

Medicare benefits are divided into three broad groups, called Part A, Part B, and Part D. Part A (also called Hospital Insurance) covers institutional care: hospital, nursing home, home health and hospice care. Part B (also called Medical Insurance) covers physician services and outpatient care. Beginning in January 2006, Medicare Part D (also called Medicare Prescription Drug Coverage) will cover some prescription drug costs for people with Medicare Part A and/or B. The benefits covered under Parts A, B, and D as well as the administration of these Parts are summarized in this chapter and discussed in more detail in later chapters.

One way to use Medicare is for a person to enroll in a Medicare Advantage (MA) plan. The Medicare Advantage program is also known as Part C of Medicare. Medicare Advantage plans include Medicare HMOs as well as a variety of other options that private companies may offer to Medicare beneficiaries. These options are described in Chapter 5.

Medicare is a federal program and is administered by a federal government agency called the Centers for Medicare and Medicaid Services (CMS). Before July 31, 2001, it was called the Health Care Financing Administration (HCFA). Private insurance companies that contract with the Medicare program handle claims for payment. These companies are called "fiscal intermediaries" for Part A claims and "carriers" for Part B claims. More information about the administration of the Medicare program is contained throughout later chapters.

Like other health insurance programs, Medicare requires premiums, deductibles and co-payments from beneficiaries. The dollar amounts for these generally change from year to year. These dollar amounts are contained in separate charts, which will be referred to throughout this manual.

II. Medicare Eligibility And Enrollment

A. Eligibility

Most people who have Medicare are automatically eligible and receive Part A benefits without paying any monthly premium. A person is automatically eligible for Medicare if she/he is:

1) age 65 or older and eligible for Social Security Title II retirement benefits;

2) age 65 or older and is eligible for federal civil service or railroad retirement benefits;

3) age 65 or older and eligible through marriage or former marriage to a spouse who is currently at least 62 years old;

4) has been receiving Social Security Disability Insurance (SSDI) or Railroad Retirement Disability Insurance for 24 months;

5) has "end-stage renal disease" (ESRD);

6) has amyotrophic lateral sclerosis (ALS), i.e. Lou Gehrig's disease;

7) qualifies for coverage as a low-income working disabled person under the Qualified Disabled and Working Individual (QDWI) program; or

8) is a transitional eligible.

Certain persons who are age 65 or older but who are not automatically eligible for Medicare may voluntarily enroll in it. In contrast to those automatically eligible for Medicare, persons who voluntarily enroll in Medicare must pay a monthly premium for Part A. This is presented in more detail in the following discussion of eligibility categories and Medicare premiums.

1. Categories of Automatic Eligibility

a. Social Security (Title II) Retirement Based Eligibility

Persons who are eligible for Social Security benefits and are at least age 65 are automatically eligible for Medicare. Persons

who elect to receive Social Security retirement benefits before age 65 do not become eligible for Medicare until they reach 65. Persons who are eligible for Social Security retirement benefits, but who elect to postpone retirement and continue working after age 65 can, if they choose, begin receiving Medicare benefits at age 65.

Persons age 65 or older who are married or were formerly married (i.e. widowed or divorced) for a minimum of ten years to someone entitled to Social Security benefits are entitled to Medicare as part of the spouse's benefits.

b. Civil Service or Railroad Retirement Benefits Based Eligibility

Railroad retirement beneficiaries and federal employees who are eligible for federal retirement benefits are eligible for Medicare under terms similar to those of Social Security retirement recipients (see above).

State and local government employees who were hired after March 31, 1986 are also eligible for Medicare in most cases.

c. Social Security & Railroad Retirement Disability Recipients

People younger than 65 with a disability are eligible for Medicare and will be automatically enrolled in Parts A and B if they have been receiving Social Security Title II or Railroad Retirement disability benefits for two years (24 months). Social Security will mail them a Medicare card about three months before their 25th month of disability benefits. Those who do not want Medicare Part B must notify Social Security by following the instructions sent with their Medicare card. Certain widows and widowers who are disabled can receive Medicare only after a 12-month waiting period.

Children who become disabled before age 22 may be eligible for disability payments and Medicare through a parent's Social Security account. For children to qualify, a parent must either

be deceased or be at least 65 and receiving Social Security benefits.

Medicare benefits can continue for up to a maximum of two years after a person with a disability has stopped receiving disability benefits because of successfully completing a trial work period. In addition, a former disability recipient who becomes disabled again within five years can begin receiving Medicare immediately.

d. Qualified Disabled and Working Individuals

In 1990, Congress expanded Medicare coverage for low-income working disabled persons with the Qualified Disabled and Working Individual (QDWI) program. People younger than 65 with a disability who lose their Social Security disability benefits due to excess earnings but whose income and assets do not exceed a certain amount, may keep their Medicare. The income and asset limitations for QDWI are contained in the chart in the Chapter on Medi-Cal and Other Programs for Low Income Beneficiaries.

Under the QDWI program, the state's Medi-Cal program (discussed in Chapter Nine) will pay any Medicare Part A premium for the person, but not the Part B monthly premium.

d. End Stage Renal Disease (ESRD)

Persons who have "end-stage renal (kidney) disease" are eligible for Medicare benefits after a three-month waiting period. They may apply at their local Social Security office for Medicare Parts A and B as soon as they are diagnosed with ESRD. Medicare coverage starts the fourth month of dialysis treatment or the month a beneficiary receives a kidney transplant. In limited circumstances, the three-month waiting period does not apply and there is no waiting period.

For people who are only eligible for Medicare because of having ESRD, their Medicare coverage ends three years after

receipt of a successful kidney transplant or 12 months after the end of dialysis. For people who are also eligible for Medicare because they are 65 or older, or because they meet one of the other qualifications mentioned in this section, their Medicare coverage, including coverage for immunosuppressive drugs used for kidney transplant patients, continues without a time limit.

Note: *Medicare will only cover these drugs if a beneficiary receives a transplant while on Medicare Part A, and if the beneficiary is enrolled in Part B at the time of needing the immunosuppressive drugs.*

f. ALS or Lou Gehrig's Disease

Effective July 1, 2001, persons who receive SSDI as a result of having amyotrophic lateral sclerosis ("ALS"), commonly referred to as Lou Gehrig's disease, are eligible for and will be enrolled in Medicare Part A and Part B the first month that they receive SSDI. Social Security will mail them a Medicare card that shows the date their Medicare Part A and Part B begins.

g. Transitional Eligibles

Transitional eligibles are those very few persons who turned 65 between 1968 and 1975 but who do not qualify for Social Security benefits. Such persons can receive Medicare if they have a certain number of "quarters of work" covered by Social Security even though their covered quarters are not enough to get Social Security.

2. Voluntary Medicare Eligibility

A person who is not automatically entitled to Medicare may be eligible to enroll voluntarily if she/he is at least age 65 and is a U.S. citizen or legal immigrant (i.e. has a "green card") who has resided in the United States for at least five years.

Although a person can enroll in Part B without enrolling in Part A, a voluntary enrollee who enrolls in Part A must also enroll in Medicare Part B. People who are entitled to Medicare Part A and/or Part B may voluntarily enroll in Medicare Part D (see Chapter 12).

Unlike automatic Part A enrollees, voluntary enrollees must pay a monthly premium for Part A benefits. Voluntary enrollees who have worked and paid into the Social Security system for 30 – 39 "quarters of coverage" pay a reduced premium, and voluntary enrollees who have not paid into the Social Security system for at least 30 "quarters of coverage" must pay the full Part A premium. The amount of the full monthly premium and the amount of the reduced premium changes yearly, and is contained in the chart at the end of this Chapter.

Effective January 1, 1998, certain former state and local public employees who have paid the Part A monthly premium for at least seven years are now entitled to receive Medicare Part A without paying any premium.

Like automatic enrollees, voluntary enrollees must pay a monthly premium for both Part B and Part D benefits. The amount of the Part B premium also changes yearly, as will the Part D premium. Medicare Part A and B premiums, deductibles and cost-sharing amounts for the current year are contained in the chart at the end of this Chapter.

Persons who cannot afford the Medicare Part A and/or B premiums may be eligible for assistance under the Qualified Medicare Beneficiary (QMB) program. Those who cannot afford the Medicare Part D premiums and other cost-sharing amounts may be eligible for extra help through the Low-Income Subsidy (LIS) program. These and other low-income assistance programs are described in Chapter 9.

B. Enrollment In Original Medicare (Parts A & B)

1. Initial Enrollment Period

Enrollment in Medicare Parts A and B is handled through local Social Security offices. For those who apply to receive Social Security benefits beginning at age 65, application for Social Security benefits should automatically trigger the Medicare application process. Social Security will mail them a Medicare card that shows the date their Medicare Part A and Part B begins. People who don't want Medicare Part B must notify Social Security by following the instructions that come with the card.

Beneficiaries who begin receiving Social Security retirement benefits prior to age 65 will also be automatically enrolled into Part A and Part B starting the first day of the month they turn age 65. Social Security will mail them a Medicare card about three months before their 65th birthday. Those who don't want Medicare Part B must notify Social Security by following the instructions that come with the Medicare card. Beneficiaries who choose to wait until later than age 65 to receive Social Security should specifically apply at their local Social Security office for Medicare benefits shortly before turning 65. Also, a beneficiary who has not received a Medicare card by her/his 65th birthday should contact the local Social Security office.

Note: *Even though an individual now turning 65 is not entitled to receive Social Security retirement benefits until several months after his/her 65th birthday, she/he is still eligible for Medicare upon turning 65).*

As mentioned above, eligible beneficiaries will be enrolled in both Parts A and B of Medicare unless they affirmatively act to notify Social Security that they do not want Part B benefits. All Medicare beneficiaries, except those who qualify for low-income programs, must pay a monthly premium for Part B benefits. The Part B premium will usually be deducted automatically from the person's monthly Social Security check.

Beneficiaries who are not automatically enrolled in the Medicare program may apply during their "initial enrollment" period (IEP), which begins three months before the month of their 65th birthday and ends three months after the month of their 65th birthday. The initial enrollment period is seven months, including the month of the person's 65th birthday.

Enrolling in Medicare during the initial enrollment period (or for those who are still working, during the "special enrollment period" described below) is important. Those who enroll during the initial enrollment period or special enrollment period pay the standard monthly Part B premium. However, those who do not enroll during the specified periods must pay a penalty for late enrollment. The amount of the penalty is discussed later in this chapter.

2. Special Enrollment Period (SEP) for Those Who Still Work

Employees and their spouses who receive health insurance through a group health plan provided by their current employer (or spouse's current employer) are not required to enroll in Medicare during their initial enrollment period if:

- they are age 65 or over and the employer has 20 or more employees; or
- they are younger than 65 and the employer has 100 or more employees.

They will have a later special enrollment period (SEP) during which they may enroll in Medicare without paying any late penalty. The special enrollment period begins the first day of the first month the person is no longer enrolled in the employer health plan, and ends eight months later (or six months in the case of people with disabilities whose group plan is involuntarily terminated).

This special enrollment period becomes available if either an employer terminates its group health plan or the employee retires. In addition, an employee covered by an employer based health plan may decide to enroll in Medicare during the general open enrollment period (GEP) (January – March of each year). The general open enrollment period is discussed in the following section.

Persons with group health insurance through current employment are not assessed a late penalty if they enroll during their special enrollment period or during any general enrollment period while still insured through current employment. (See Chapter Eight on "Medicare for People Who Are Working.")

Some employers, especially very large employers or unions, provide retirement health coverage. It should be noted that these special enrollment rules for those who still work do not apply to those who have employer-based insurance through retirement. They apply only to those who have such health coverage through current employment. Beneficiaries who have retirement coverage often report that they have employer based health coverage. Advocates helping those with Medicare questions must find out whether such coverage is through current employment or whether it is a retirement benefit in order to advise beneficiaries correctly about Medicare issues.

In addition, there are a number of issues that should be taken into account by Medicare beneficiaries who are entitled to group health insurance through current employment. These issues are discussed in Chapter Eight.

3. General Enrollment Period

A person who misses his or her initial enrollment period or special enrollment period may still enroll in Medicare. However, this may be done only during January – March of each year, which is referred to as the "general enrollment period" or "GEP." If a person

enrolls in a general enrollment period, Medicare coverage will be effective July 1 of that calendar year.

4. Late Enrollment

An individual may enroll during her/his initial enrollment period or special enrollment period without penalty. Those who do not enroll during these specified periods, but rather enroll in a later general enrollment period, will have to pay a monetary penalty.

The penalty for late enrollment in Medicare Part A is ten percent of the amount of the Part A premium at the time of enrollment. The penalty is assessed for twice the number of years the individual delayed enrolling in Medicare.

The penalty for late enrollment in Medicare Part B is more complicated. It equals ten percent of the current Part B premium for every 12-month period the individual delayed enrolling in Medicare. Thus, if a person delayed enrolling in Medicare for a period of 24 months, the penalty would be 20 percent of the current Part B premium. The Part B premium penalty must be paid as long as that person remains enrolled in Medicare.

In California, persons who have Medi-Cal can enroll in Medicare Part B at any time without being assessed a premium penalty. This is because of an agreement between the California Medi-Cal program and Medicare. The same is not true of Part A.

EXAMPLE:

Jim R. turned 65 in January 2001. He did not enroll in Medicare until February 2003, a lapse of 25 months. Because he was a voluntary enrollee, Mr. R. will have to pay ten percent of the 2003 Part A premium for four years (two times the two years he delayed enrolling).

EXAMPLE:

Geri M. elected to retire early at age 62. In January 1994, when she turned 65, she was automatically enrolled in Medicare Part A but declined Medicare Part B. Four years later, when she turned 69, she applied for Part B, a late enrollment of 48 months. Geri M. will not have to pay any Part A penalty, but she will have to pay an additional 40 percent (ten percent of the 1998 Part B premium x four 12-month periods) for her Part B premium for the rest of her life.

C. Enrollment In Medicare Part C And Part D

Enrollment rules for Medicare Advantage plans (Medicare Part C) are changing as of January 2006 in an effort to coordinate with the enrollment rules of Medicare Part D. These rules for Medicare Part C and D are discussed in detail in Chapters Five and Seven, respectively.

III. Summary of Medicare Benefits

Medicare covers only health care services that are medically reasonable and necessary. In recent years Medicare has also begun covering some preventive and routine health care services. Although many of these services are still excluded, the list of covered preventive services is growing. Because Medicare will begin offering some prescription drug coverage through Medicare Part D in January 2006, the most significant gap in Medicare coverage is in the area of long term care. The specific gaps in coverage as well as the preventive services covered are discussed in Chapter Four.

With very few exceptions, Medicare will pay only for services provided within the borders of the United States. When a beneficiary living near a border has an emergency, Medicare will pay for treatment if the closest facility is in Canada or Mexico. Medicare will also pay for emergency services in Canada for persons traveling between Alaska and another

state. *Note: In addition, services rendered on board a ship in a U.S. port or within six hours of when the ship arrived at, or departed from, a U.S. port, are considered to have been furnished in U.S. territorial waters, and may be covered by Medicare.*

Part A (Hospital Insurance) of Medicare generally covers hospital inpatient care, skilled nursing facility care, home health care and hospice care. Each type of care has its own set of criteria that must be met in order for the care to be covered, as well as its own set of limits on the amount of care that will be covered.

Part B (Medical Insurance) of Medicare generally covers doctors' care and outpatient care. This includes hospital outpatient visits, clinics, ambulance services, durable medical equipment, diagnostic tests and mental health services. Since 1998, some home health care is covered under Part B rather than under Part A.

Together, Parts A and B are often referred to as "fee-for-service" Medicare or as "Original Medicare."

Part C of Medicare, called Medicare Advantage (previously called "Medicare + Choice"), refers to the various kinds of private insurance plans offered to Medicare beneficiaries as an alternative way to receive their Medicare benefits. These private insurance companies have specific contracting arrangements with Medicare, and may offer Medicare managed care plans such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) as well as other types of plans including Private-Fee-For-Service (PFFS) plans, Medical Savings Accounts (MSAs), and Special Needs Plans (SNP). (See Chapter Five for more information). All Medicare Advantage plans must offer, at a minimum, all of the health care services covered by Medicare Parts A and B. In addition, many Medicare Advantage plans may offer extra benefits generally not covered by Medicare, and/or decide to offer Part D benefits through their own Medicare Advantage Prescription Drug plan (MA-PD).

As mentioned above, starting in January 2006, Part D of Medicare provides some drug coverage, both generic and brand name drugs, through private prescription drug plans (PDPs) or Medicare Advantage Prescription Drug plans (MA-PDs). While each plan is required to cover certain categories (refers to drugs that generally reflect specific diseases) and classes (refers to drugs underneath categories that are divided based upon common chemical make-up) of drugs and to cover at least two drugs in each category and class, Part D plan formularies (lists of covered drugs) may vary greatly. Beneficiary cost-sharing amounts (co-payments) will also vary by plan and depend on whether the covered drug is a preferred or non-preferred drug, generic or brand name, or on a high or low cost-sharing tier. The Medicare Part D benefit is discussed in detail in later chapters.

IV. Summary of Medicare Costs

Even with Medicare coverage, Medicare beneficiaries often still face very high out of pocket costs for health care. The following summary reflects Medicare's costs to beneficiaries. A chart reflecting beneficiaries' costs for Medicare covered services is contained at the end of this chapter.

A. Premiums

Medicare beneficiaries who are automatically entitled to Medicare do not pay any premium for Medicare Part A. Beneficiaries who are not automatically entitled to Medicare, but rather enroll in it voluntarily, must pay a monthly premium for Part A. Voluntary enrollees who have worked in this country and paid into the Social Security system for 30 – 39 quarters of coverage pay a reduced Part A premium. The amount of the full and reduced monthly premium changes each year. See the charts at the end of this chapter for this year's premium amounts.

All Medicare beneficiaries must pay a monthly premium to obtain and keep Medicare Part B. Generally, the Part B premium is designed to pay for 25 percent of the cost of Part B benefits for all Medicare beneficiaries nationwide. Like the Part A premium for voluntary

enrollees, the amount of the Part B premium changes annually. The year 2005 marked the largest annual increase in the Part B premium in 15 years. While it increased 13.5 percent in 2004, the premium increased 17.5 percent in 2005. This trend, combined with the projected annual increase in the Part D premium (estimated to be about $37 per month in 2006), will consume larger percentages of beneficiaries' income, most likely causing more people to apply for low-income assistance and Medi-Cal.

See the chart at the end of this chapter for this year's premium amount. Starting in 2007, Part B premium amounts will also be income-related. People with annual incomes at or above $80,000 for an individual and $160,000 per couple will have to pay more for their Part B premium than those with lower incomes.

Medicare beneficiaries who choose to enroll in a Medicare Advantage plan still must pay any Part A or Part B premium they would pay if they remained in Original Medicare.

B. Deductibles And Co-payments

In general, a deductible refers to the amount the beneficiary must pay before Medicare will pay for a particular service. Co-payments or co-insurance refers to the amount of cost-sharing a beneficiary must pay for each service for which Medicare pays. In Medicare, the amount of the deductible and co-payments differs for Parts A and B, and also differs under Part A depending on the type of health care provided, the provider or facility.

For inpatient hospital stays, a Medicare beneficiary must pay a first-day deductible before Medicare will pay anything for the stay. Once that first-day deductible has been met, Medicare pays in full until day 60 of hospitalization. For each of the 61 – 90 days of hospitalization, the beneficiary must pay a daily co-payment. The same is true for lifetime reserve days (which are described in Chapter Two which covers Part A Benefits). The dollar amounts for the deductible and co-pay are contained in the chart at the end of this chapter.

For skilled nursing facility (SNF) stays, a Medicare beneficiary does not pay anything for the first 20 days of a Medicare covered stay. Thereafter, , the beneficiary must pay a daily co-payment until the maximum available number of days is reached.

Home health care services generally do not require any beneficiary payment, except for a 20 percent co-payment for durable medical equipment.

Similarly, the out of pocket cost to beneficiaries for hospice care is very minimal. Beneficiaries must pay a maximum of $5 per prescription drug (drugs used for symptom control or pain relief) and a daily co-payment of five percent of the cost for inpatient respite with a maximum equal to the hospital first day deductible.

Under Part B, beneficiaries must pay an annual deductible before Medicare will pay for Part B care. In 2005, the annual deductible is $110. This amount will increase yearly by the same percentage as the Part B premium increase (estimated to be $115 in 2006 and $166 in 2013). Once the one-time per year deductible is met, the beneficiary co-payment is generally 20 percent of the Medicare approved amount. However, this is a very general rule of thumb and varies in certain circumstances. For example, no deductible or co-payment is charged for laboratory or diagnostic tests. As another example, doctors who do not accept assignment (a concept that is explained in a later chapter regarding Part B benefits) may charge up to 15 percent above the Medicare approved amount plus the 20 percent of the Medicare approved amount. All of these variations are discussed in Chapter Four regarding Part B benefits.

Under Part D, beneficiaries must also pay an annual deductible before Medicare will begin paying some of their prescription drug costs. In 2006, the deductible under the standard drug benefit is $250; this amount will increase annually. Beneficiaries will also have some substantial cost-sharing amounts. People who have low-incomes and assets may qualify for a Low-Income Subsidy (LIS) program

to help cover these costs (see Chapters Nine and Twelve for more information).

The amounts of the Medicare Part A and B premiums, deductibles and co-payments for the current year are contained in the charts at the end of this chapter. Part D premiums will vary depending on the Part D plan. The standard benefit for Medicare Part D is explained in Chapter Twelve.

Beneficiary Costs For Medicare Benefits
Year 2005

Part A (Hospital Insurance)	Beneficiary Pays
Monthly Premium	
Automatically Eligible	$0
Voluntary Enrollee	
30 – 39 quarters of coverage	$206 per month
0 – 29 quarters of coverage	$375 per month
Inpatient Hospital Care[1]	
Day 1 – First day deductible	$912
Days 2 – 60	$0
Days 61 – 90	$228 per day
60 Lifetime Reserve Days	$456 per day
Beyond Lifetime Reserve Days	All costs
Psychiatric Care	All costs beyond 190 days in a lifetime
Skilled Nursing Facility Care[1]	
Days 1 – 20	$0
Days 21 – 100	$114 per day
Beyond day 100	All Costs
Home Health Care[2]	
Durable Medical Equipment	20% of Medicare approved amount
All Other Home Health Care	$0
Hospice Care	
Prescription Drugs	Maximum $5 per prescription
Inpatient Respite Care	5% of cost; maximum $912

1. Covered days are for each "spell of illness" or "benefit period."
2. Some home health care is covered under Part B, but the beneficiary costs are the same under Part A and Part B.

Beneficiary Costs For Medicare Benefits
Year 2005

Part B (Medical Insurance)	Beneficiary Pays
Monthly Premium	$78.20
Annual Deductible	$110
Co-payment	20% of Medicare approved amount
Charges Beyond Medicare Approved Amount: Physician Charges: Assignment Not Accepted Durable Medical Equipment: Assignment Not Accepted	 Additional 15 percent above the Medicare approved amount Additional costs beyond Medicare approved amount
Special Rules for Specific Types of Services: Clinical Laboratory Tests Hospital Outpatient Services Outpatient Psychiatric Services Ambulance Services	 $0 (no deductible, no co-payment) $912 maximum co-payment 50% of Medicare approved amount (plus 15 percent above Medicare approved amount if no assignment) 20% of Medicare approved amount

[This Page Intentionally Blank}

Chapter 2

Medicare Part A Benefits (Hospital, Skilled Nursing Facility and Hospice Care)

I. Introduction

As a general rule, all health care services and items must be "medically reasonable and necessary" in order for Medicare to cover them. Under Medicare Part A (Hospital Insurance), services provided in different types of medical facilities must also meet additional requirements in order for Medicare to cover them. For example, a person must be "homebound" in order to obtain Medicare coverage for home health care. Some Part A benefits, such as inpatient hospital coverage and skilled nursing facility coverage, have limits on the number of days that Medicare will cover.

The types of benefits and services covered under Medicare Part A, the requirements for obtaining Medicare coverage of such services, and the cost to the beneficiary for such services are all discussed in this chapter. This chapter will discuss Medicare Part A benefits in the following order: inpatient hospital care; skilled nursing facility care; and hospice care. Home health care, which is sometimes covered under Part A and sometimes covered under Part B, is discussed in Chapter 3.

All Medicare Advantage plans (which include Medicare HMOs, regional Preferred Provider Organizations (PPOs), Special Needs Plans (SNPs), Private-Fee-for-Service Plans (PFFS), and Medical Savings Accounts (MSAs)) must cover at least all of the benefits covered under Medicare Parts A and B. Some may also cover Part D benefits, but they are not required to do so. (See Chapter Twelve for more information).

II. Inpatient Hospital Care

A. Benefits

To be covered by Medicare, hospital services must be received in a facility that has been "certified" by Medicare. However, almost all hospitals are Medicare certified. Part A covers hospital bed and board, routine nursing services, drugs provided for use in the hospital, equipment and medical appliances, physical and other therapy provided on an inpatient basis, and the services of residents and interns. Physicians' services received in the hospital, however, are billed separately under Part B.

Note: *Medicare Part D, Medicare's drug benefit beginning in January 2006, does not cover drugs that are already covered under Medicare Parts A and B. This is true even if a beneficiary is not enrolled in Part(s) A and/or B. See Chapter Twelve for more information on Medicare Part D.*

Medicare does not cover luxury items and extraordinary services such as private rooms or private duty nurses, unless they are medically necessary.

There is a limit on the total number of days of hospitalization that Medicare will cover. However, this limit is very high and it is extremely rare for a beneficiary to use up his or her Medicare covered hospital days.

Medicare covers a total of 90 days of a hospital stay in each "benefit period." The "benefit period" is also called a "spell of illness." It is important to understand what is meant by the term "spell of illness" or "benefit period" in order to understand how long Medicare will cover a hospital stay. A benefit period begins the day a beneficiary is admitted to the hospital for a Medicare covered stay and continues until 60 days after the end of a Medicare covered hospital or skilled nursing facility (i.e., nursing home) stay. Once the beneficiary has not received Medicare covered hospital or nursing home care for 60 days, if the beneficiary re-enters the hospital, a new benefit period begins.

With each new benefit period, Medicare will cover up to 90 days of hospitalization (as long as it is medically reasonable and necessary).

> ***EXAMPLE:***
>
> *Mr. Smith enters the hospital on March 1, and, after being an inpatient for two weeks, is discharged and sent home (he has so far used 14 inpatient hospital days in his benefit period). Three weeks later, he is hospitalized again for the same medical condition. When he enters the hospital again, he begins day 15 of inpatient coverage; he does not begin a new benefit period because he has not been out of both the hospital and skilled nursing facility for at least 60 days.*

In addition to the 90 days of hospital coverage in each spell of illness, Medicare also covers an additional 60 "lifetime reserve" days. Each lifetime reserve hospital day may be used once and is then never again available. Unlike the first 90 days of hospital coverage, the lifetime reserve days do not get renewed after a spell of illness is ended.

Technically, a chronically ill person who goes back and forth between the hospital and nursing home could remain in the same spell of illness long enough that he or she uses up Medicare coverage for hospital stays. However, the reality is that the average length of a Medicare covered hospital stay is less than ten days. Thus, it is extremely unusual for a beneficiary to use up Medicare hospital coverage.

1. Psychiatric Hospital Care

Inpatient psychiatric care in a specialized psychiatric hospital is covered under the same rules regarding "benefit period" as the inpatient hospital benefit. Thus, Medicare will cover up to 90 days of inpatient psychiatric care in a spell of illness, and will also cover an additional 60 lifetime reserve days. However, unlike the

inpatient hospital benefit, coverage of inpatient psychiatric care is limited to a lifetime benefit of 190 days.

B. Beneficiary Costs For Hospital Stays

Medicare requires some cost sharing in each benefit period. At the outset of a benefit period, the beneficiary is responsible for a first day, inpatient hospital deductible. After this "first day deductible" is met, there are no co-payments until day 61 of a hospitalization. Beginning on day 61 of hospital care in a benefit period, a daily beneficiary co-payment is required. The daily co-payment remains the same for days 61 – 90. There is a different daily co-payment for the 60 lifetime reserve days. The amount of the first day deductible, the co-payment for days 61 – 90, and the co-payment for lifetime reserve days are all set forth in the chart at the end of the first chapter, called Medicare Overview.

C. Medicare Payment For Hospital Stays

Generally, hospitals are paid by Medicare on a prospective payment, or fixed price, basis. Medicare's prospective payment system (PPS) for inpatient hospital care is based upon "diagnosis related groups" or "DRG"s. Under Medicare's DRG system, the amount of payment made to a hospital is determined at the time of a patient's admission to the hospital. At the time of hospital admission, each patient is assigned one DRG for the hospital stay, and the hospital receives a corresponding flat rate regardless of the actual number of days in the hospital or the actual services received. There are approximately 500 different DRGs.

In certain very unusual cases, additional payment can be made to the hospital when a patient's stay far exceeds the average number of days for a diagnosis within a particular DRG.

The DRG system provides a financial incentive for hospitals to discharge patients as soon as possible, because the hospitals are paid the same amount of money for a patient regardless of the length of that patient's hospital stay. Thus, Medicare hospital patients

have special protections, including appeal rights, to prevent being discharged from the hospital before being medically ready for discharge. These protections include the requirement that Medicare patients be given a written Notice of Non-Coverage and be given the right to an immediate, expedited review of the discharge if the patient requests it. Medicare patients are also entitled to a written discharge plan. Thse rights are discussed in Chapter Six.

The Medicare program contracts with private monitoring agencies, called Quality Improvement Organizations (QIOs), to oversee the quality of care provided by hospitals to Medicare beneficiaries. QIOs are supposed to review the correctness of DRG information supplied by hospitals, the medical necessity for hospital admissions, and beneficiary appeals of hospital discharges (discussed below).

The QIO for California is Lumetra. Its address is: One Sansome Street, Suite 600, San Francisco, CA 94104-4448; and its telephone number is: (800) 841-1602 or (415) 677-2000.

III. Skilled Nursing Facility Care

A. Benefits

Medicare has very specific criteria that must be met before it will cover a skilled nursing facility (commonly referred to as a "nursing home") stay. These criteria are discussed in the section immediately below. Also, like Medicare's coverage of hospital stays, Medicare's coverage of nursing home stays is based on the concept of a "benefit period" or "spell of illness." This concept is described earlier in this Chapter in the section on Inpatient Hospital Care. As long as all coverage criteria are met, Medicare covers a maximum of 100 days of skilled nursing home care in each benefit period.

Although technically Medicare covers up to 100 days in a nursing home in each benefit period, this time frame is misleading. Due to Medicare's coverage criteria, the reality is that Medicare generally covers very little care in a nursing home. The average Medicare

covered nursing home stay is less than ten days. Even if Medicare covers a nursing home stay in the beginning, such coverage often stops shortly after day ten based on the belief that the person no longer meets the coverage requirements. Also, as discussed below, nursing homes are the gatekeepers to obtaining Medicare coverage of a nursing home stay, and the nursing homes have financial incentives to limit coverage.

Even if all of the criteria for Medicare coverage of a nursing home stay are not met and thus the nursing home stay is not covered under Medicare Part A, Medicare Part B may pay for certain services received in a nursing home, such as x-rays, laboratory work, physicians' visits, and physical therapy. Medicare Part B does not, however, cover durable medical equipment, including oxygen, for nursing home patients. Part B services other than physicians' services must be provided and billed to Medicare through the nursing home. After Medicare Part D drug coverage begins in 2006, Medicare Part A will continue to cover drugs in the nursing home during a covered Part A stay; Medicare Part D will not cover such drugs.

1. Requirements for Coverage

Medicare pays for a skilled nursing facility (SNF) stay only if all of the following criteria are met:

- The SNF is Medicare-certified.
- The patient has been hospitalized for at least three consecutive days just prior to entering the SNF. (A three-day hospital stay within the 30 days prior to entering the nursing home will qualify if the hospitalization was for the same condition as the patient needs SNF care).
- The patient must need "skilled" nursing or rehabilitation services on a daily basis. Medicare's definition of "skilled" services is discussed below.
- The skilled services must be ordered by the patient's physician.

- The skilled services must be medically reasonable and necessary.
- The SNF must be the most efficient and economical means of providing the needed services.

The requirement that the beneficiary must need skilled services on a daily basis is the one that causes the most trouble in obtaining Medicare coverage of a SNF stay. This requirement is discussed in the following section.

a. Daily Skilled Services

The aspect of Medicare's rules that surprises most people is the definition of what is considered to be "skilled care." Medicare defines skilled care as a nursing or rehabilitation therapy service that requires the special skills of technical or professional health personnel (e.g., a registered nurse, licensed practical/vocational nurse, physical therapist, occupational therapist, speech pathologist or audiologist) on a daily basis.

The restoration potential of a patient is not the controlling factor in determining whether a patient needs skilled care. A patient may need skilled care to prevent deterioration or to maintain current functioning. The totality of a patient's mental and physical condition should be considered in determining whether skilled care is necessary for management of a patient's care plan or for observing and assessing the patient's condition.

Unfortunately, most of the services that people in nursing homes need are considered to be "custodial" or "personal care services" and not "skilled." For example, assistance with the activities of daily living (ADLs) is not considered to require skilled care. Thus, someone who needs assistance with eating, going to the bathroom and getting in and out of bed is unlikely to meet Medicare's skilled care requirement. Whether or not a person requires skilled care is supposed to be an individualized assessment based on the total needs of the person, and not

a pre-set determination based on a person's diagnosis or particular medical condition.

Just as the term "skilled" services has a different meaning in Medicare than most people would assume, so does the requirement that skilled services be needed on a "daily" basis. If the skilled services the beneficiary requires are nursing services, the "daily" requirement does mean seven days per week. However, if the beneficiary needs skilled therapy services, and the SNF has them available only five or six days per week, Medicare's criterion that the skilled care be needed "daily" will still be met.

b. Beneficiary Costs For Nursing Home Stays

As stated above, Medicare covers a maximum of 100 days of nursing home care in each benefit period. Assuming that Medicare's coverage rules are met, Medicare pays in full for the first 20 days. The patient has no co-payments. After day 20, the patient must pay a co-payment for each Medicare covered day. See the chart at the end of the first Chapter, "Medicare Overview," for the amount of the daily co-payment for days 21 – 100. Regardless of a patient's need for care, Medicare does not cover nursing home care beyond day 100 in a benefit period.

c. Medicare Payment For Nursing Home Stays

The Balanced Budget Act of 1997 (BBA) changed the way in which Medicare pays SNFs. All SNFs have been on the new system of payment since January 1, 1999. Under the prior system, Medicare paid SNFs an amount based upon the SNF's costs. Under the new system, Medicare pays SNFs based upon an assessment of how much care a person needs.

Advocates should be on the alert for nursing homes advising Medicare beneficiaries that Medicare will not cover a nursing home stay.

d. Financial Protections For Medicare Beneficiaries

At the time of admission, the nursing home itself makes an informal determination as to whether it thinks Medicare will cover the person's nursing home stay. The nursing home again makes this informal assessment as the person's stay progresses. Frequently, at the time of admission or sometime during a person's nursing home stay, the nursing home will advise the person that Medicare will not cover the stay or will no longer cover the stay.

Medicare beneficiaries and their families should keep in mind that the nursing home can be wrong in its assessment of Medicare coverage. For a variety of reasons, nursing homes would rather have a person pay privately than have Medicare pay for the stay. Fortunately, there are several protections for patients who are told that Medicare will not or will no longer cover their nursing home stay.

1. Notice of Non-Coverage

First, whenever a nursing home advises that Medicare will not cover a nursing home stay, it must provide a written Notice of Non-Coverage. This Notice must include:

- the date that Medicare coverage will end;
- the reason that Medicare will not cover the stay;
- an explanation of how to request that the SNF submit a Medicare claim anyway;
- a statement that if a Medicare claim is not submitted, the denial of coverage can not be appealed;
- information that the patient is not required to pay for any of the stay unless and until Medicare itself makes a decision to deny coverage; and

- a place for the patient or his/her representative to sign, acknowledging receipt of the notice.

In addition, patients or family members are asked to check one of two boxes:

- ❑ I do want my bill for services I continue to receive to be submitted to the intermediary for a Medicare decision. (You will be notified when the bill is submitted).
- ❑ I do not want my bill for services submitted to the intermediary for a Medicare decision.

2. Demand Bills

The choice of whether to insist that Medicare be billed can be confusing. However, in order for Medicare to be billed, the first box must be checked. A claim submitted by the nursing home at the patient's request is commonly referred to as a "demand bill." The intermediary that is referred to is one of the companies that processes nursing home claims for the Medicare program.

3. Prohibition Against Advance Deposits and Third Party Guarantors

As a general guideline, the patient should always have the nursing home submit a Medicare claim. Checking the first box and thereby requesting that Medicare be billed brings some financial protection to the patient. First, a nursing home cannot charge or collect any money, including any advance deposit, unless and until Medicare issues a denial of coverage. The nursing home may not bill the patient while awaiting the decision of the Medicare intermediary. Second, for all nursing home patients, the nursing home may not require a third party (such as a relative or friend) to guarantee payment.

Another protection for Medicare beneficiaries is, as with any type of coverage decision, the right to appeal a denial. Again, a Medicare patient or his/her family should always ask the nursing home to submit a Medicare claim. Otherwise, there will be no formal Medicare determination to appeal. If the claim is approved when it is submitted, there will be no need to appeal it. If the claim is denied by the Medicare fiscal intermediary (the company that processes Medicare Part A claims), that denial may be appealed by writing to the intermediary within 60 days from the date of the denial, requesting reconsideration. If the reconsideration decision is still a denial, there are several more avenues of appeal that may be pursued. The appeals process for nursing home coverage denials is included in Chapter Six, "Medicare Claims and Appeals."

Medicare Advantage enrollees are entitled to receive an advance written Notice of Non-Coverage from their Medicare Advantage plan or the SNF. However, there is no demand bill procedure. To appeal a Notice of Non-Coverage the patient must use the Medicare Advantage appeals process. Medicare Advantage plan enrollees may request that the appeal be expedited. Information regarding MA expedited appeals and standard appeals (ones that are not expedited) is provided in Chapter Six regarding Appeals.

Note: *As of July 1, 2005, beneficiaries with original fee-for-service Medicare also have expedited appeal rights when being discharged from a SNF. See Chapter Six for more information.*

IV. Hospice Care

A. Benefits

Hospice care is designed for persons who are terminally ill and whose doctor expects that they have less than six months to live. The goal is to keep the patient comfortable rather than to provide cure-oriented treatment.

Hospice benefits are provided under Medicare Part A. Medicare will pay for care from an approved hospice only if a doctor certifies that the patient has less than six months to live. Even if the patient does not actually die within six months, Medicare will continue to cover the hospice care; the patient must merely be expected to die within six months.

If a patient chooses the hospice benefit over the standard Medicare benefit, traditional cure-oriented Medicare-covered services are replaced with hospice care. However, if a patient is receiving hospice care and needs treatment for a condition unrelated to the terminal illness, Medicare will pay for medical care for the unrelated injury or illness. For example, if a person with terminal cancer has chosen the hospice benefit and then breaks an arm, Medicare will still pay for treatment of the broken arm.

> ***EXAMPLE:***
>
> *Ms. Roberts is in a nursing home with a plaster cast on her leg. Although the cast would not normally indicate a need for skilled care, because Ms. Roberts has a pre-existing peripheral vascular disease, she may need skilled nursing or skilled rehabilitation personnel to watch for complications.*

EXAMPLE:

Mr. Coots entered a nursing home directly following a two-week hospital stay. His acute and chronic conditions include chronic obstructive pulmonary disease – which requires the frequent administration of oxygen – and gastric reflux, which requires that he be in an upright position as much as possible. In addition, he requires frequent monitoring of his heart and has a Foley catheter in place.

His doctor has prescribed a variety of oral medications and frequent monitoring of his blood oxygen needs for possible changes in oxygen levels. Because of confusion and agitation, Mr. Coots frequently pulls out the nasal oxygen tube and is slumped over more often than not, aggravating the gastric reflux problem.

Mr. Coots needs close monitoring and evaluation of his overall medical condition, which constitutes skilled care.

As stated above, a physician must certify that the patient has less than six months to live. Under the hospice benefit, it is not necessary for the patient to receive skilled services in order to obtain the personal care services of a home health aide or homemaker, or a medical social worker or bereavement counselor.

During the terminal illness, a Medicare beneficiary is entitled to two 90-day periods of hospice care and subsequent unlimited numbers of periods of 60 days each. The need for each period of hospice coverage must be certified by the attending physician or medical director of the hospice program. A beneficiary can elect to return to the standard Medicare benefit at any time. However, the beneficiary will forfeit any remaining days in that hospice period. Any unused hospice periods remain intact.

Medicare Covered Skilled Nursing Facility Care

Examples Of Skilled Rehabilitation Services

- Ongoing assessment of rehabilitation needs and potential.
- Therapeutic exercises or activities, which, because of the type of exercises employed or the condition of the patient, must be performed by or under the supervision of a qualified therapist or occupational therapist.
- Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality.
- Range of motion exercises, which are part of the active treatment of a specific disease state that has resulted in a loss of, or restriction of, mobility.
- Maintenance therapy, when the specialized knowledge and judgment of a qualified therapist is required to design and establish a program based on an initial evaluation and periodic reassessment of the patient's needs.
- Ultrasound, short-wave, and microwave therapy treatments by a Physical Therapist.
- Hot pack, hydro-collator, infrared treatments, paraffin baths, and whirlpool, in cases in which the patient's condition is complicated and the skills and judgment of a physical therapist are required.
- Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.

1. Types of Services Covered

Medicare hospice services are provided primarily in the patient's home. Services covered under the hospice benefit are the same as those provided under the home health care benefit with the addition of homemaker and housekeeping services, patient and family counseling, and short-term inpatient care.

The inpatient care benefit includes both respite care to provide relief for family care givers, and procedures necessary for pain control and acute and chronic symptom management. Respite care can be provided only on an intermittent, non-routine and occasional basis, for not more than five days at a time. Although Medicare allows covered inpatient care to be provided at a hospital, the reality is that most hospice inpatient care is provided in nursing homes.

Effective as of October 1, 2004, in addition to Medicare's coverage for services from a physician who certifies a beneficiary as terminally ill, Medicare now also covers the services of a nurse practitioner. These services are only covered if a beneficiary chooses a nurse practitioner instead of a physician to have the most significant role in the determination and delivery of her/his medical care. Although a nurse practitioner is still not authorized to certify a beneficiary as terminally ill, she/he can now review hospice plans of care.

In addition, as of January 1, 2005, Medicare now covers a one-time hospice consultation for terminally ill beneficiaries who are not yet using the hospice benefit. During the consultation, the physician, who must be either a hospice medical director or an employee of a hospice program, will evaluate a beneficiary's pain and symptom management needs, provide counseling regarding end-of-life issues and care options, and advise the individual on advanced care planning.

B. Beneficiary Costs

If an individual elects hospice care, Medicare will cover everything except for a small co-payment for drugs and biologicals used for symptom control or pain relief (five percent of the cost, not exceeding $5 for each prescription); and for inpatient care (five percent of the amount Medicare pays for each inpatient day, capped at the Medicare inpatient hospital deductible for that year).

C. Medicare Advantage Plans And Hospice Care

Effective January 1, 1999, Medicare Advantage (MA) plans may enroll beneficiaries who are already receiving the hospice benefit, and they must provide or pay for hospice care for beneficiaries who become terminally ill after enrolling in the Medicare Advantage plan and who choose the hospice option. If a terminally ill Medicare beneficiary who is in a hospice program wants to enroll in a MA plan, the MA plan is required to accept that enrollee.

V. Advance Directives/Medical Decision Making

The right of people to make decisions about the medical treatment they receive is widely acknowledged. Indicating medical treatment preferences by completing an "advance directive" can help ensure that patients' wishes are respected. (A Durable Power of Attorney for Health Care is one type of an advance directive). The federal Patient Self-Determination Act (PSDA) helps ensure that patients are given adequate information about their medical condition, needs and treatment, and that patients' wishes regarding their medical treatment are followed.

The PSDA requires that certain medical providers must inform patients of their rights under state law to make their own medical decisions, including the right to complete an advance directive. The PSDA applies to all hospitals, skilled nursing facilities, home health agencies, hospices and Medicare Advantage plans that accept

payment from Medicare or Medicaid (called Medi-Cal in California). In California, such medical providers must give people a brochure entitled "Your Right to Make Decisions About Medical Treatment," which is endorsed by the California Department of Health Services. This brochure describes California law regarding patients' rights with respect to medical decision-making and also describes the types of advance directives allowed by California law.

[This Page Intentionally Blank}

Chapter 3

Medicare Home Health Care Benefits (Parts A and B)

I. Introduction

Home health care may be the Medicare benefit with which beneficiaries and medical providers are least familiar. Most people simply assume that home health care will be covered when they need it. Unfortunately, many older Americans and those who care for them are wrong. The reality is that Medicare coverage rules are generally applied in a very strict manner that results in Medicare coverage of home health care in fairly limited circumstances. Thus, knowledgeable and assertive advocacy is often much needed to obtain needed home health care for beneficiaries.

From the beginning of the Medicare program until the Balanced Budget Act of 1997, all home health care was covered by Medicare under Part A. Effective January 1, 1998, beneficiaries who have both Part A and Part B have their home health visits covered under Part A if their situation falls within certain additional criteria. Beneficiaries who do not meet these additional criteria still have their home health care covered, but it is paid for under Part B.

II. Home Health Care Benefits

A. Requirements For Medicare Coverage

In order for Medicare to pay for home health care services, all of the following conditions must be met:

- the home health agency must be Medicare-certified;

- the beneficiary must be confined to the home, i.e. be homebound;
- the beneficiary must be under the care of a physician, who must develop and sign a treatment plan; and
- the beneficiary must need at least ONE of the following skilled services:
  - ◊ physical therapy;
  - ◊ speech therapy;
  - ◊ ongoing occupational therapy; or
  - ◊ intermittent skilled nursing care.

1. The Homebound Requirement

An important requirement for home health care is that the beneficiary be homebound as a result of a medical condition. Unfortunately, Medicare's definition of homebound is ambiguous. A beneficiary does not have to be bedridden to be considered "confined to the home." However, the beneficiary's condition should be such that:

- there exists a normal inability to leave the home;
- leaving home requires a considerable and taxing effort; AND
- absences from the home are:
  - ◊ infrequent;
  - ◊ of relatively short duration; OR
  - ◊ due to the need to receive medical treatment.

In a law effective December 21, 2000, Congress made clear that a person is still considered homebound in the following two circumstances: (a) even if he or she has absences from home that are due to the need to receive health care treatment, including regular participation in an adult day care program; and (b) even if

he or she has absences from home for the purpose of attending a religious service.

- A beneficiary's home, or "residence," means anywhere the beneficiary currently lives. However, Medicare never considers a hospital or skilled nursing facility to be a beneficiary's residence, even when the nursing facility stay is not a Medicare covered stay. Thus, Medicare does not pay home health benefits when a beneficiary is in a nursing home.

2. Skilled Services

In order to obtain Medicare coverage for home health care, the beneficiary must require services that are considered to be "skilled." To qualify as skilled, a service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. Services that are often considered to be "custodial" or not "skilled" can be considered skilled if the patient's overall medical condition requires skilled nursing or rehabilitation personnel to manage or perform the treatment plan, observe the patient's progress, or evaluate the need for changes in treatment. Thus, the beneficiary's specific diagnosis or conditions should not determine whether or not skilled care is needed. It is the *kind of service* needed, in light of the patient's overall condition, and the *skills required for its performance* that determine whether a service is skilled.

3. Additional Criteria Mandated By The Balanced Budget Act of 1997

The additional criteria that makes Medicare covered home health care come under Part A, effective January 1, 1998, are the following:

- The beneficiary had a prior stay – at least three consecutive days – in a hospital or, following a hospital stay, in a skilled nursing facility stay;

- The home health services are being provided within 14 days of being discharged from the hospital or skilled nursing facility; AND
- The home health services in question do not exceed the new limit on the number of home health care visits covered under Part A – 100 visits per "spell of illness" (spell of illness is discussed below).

These criteria are referred to generally as the Part A "post-institutionalization" criteria. If these criteria are not met, home health care can still be covered under Part B.

The concept of a "spell of illness" is similar to a spell of illness for purposes of inpatient hospital coverage and skilled nursing facility coverage. A spell of illness for Part A home health care begins the first day a beneficiary receives home health care following a prior hospital or skilled nursing facility stay. A spell of illness ends at the end of the first 60 days during which the beneficiary is neither in a hospital nor a nursing home, nor receiving home health care.

Note: *Medicare beneficiaries who do not meet the Part A additional "post institution" criteria may still obtain home health care under Medicare Part B.*

B. Types Of Home Health Services Covered

As long as the beneficiary meets all of the conditions for Medicare coverage (discussed above), the specific services are ordered in the physician's treatment plan, and the services are medically reasonable and necessary, Medicare will cover the following types of home health care services:

- skilled nursing care;
- physical, occupational or speech therapy;
- medical social services;
- home health aide services;

- medical supplies (other than drugs and biologicals); and
- durable medical equipment.

Contrary to information often provided to beneficiaries, Medicare does cover certain home health aide services, but only if skilled services are being covered. This is true even though home health aide services are considered to be custodial rather than skilled care. Covered home health aide services include assistance with bathing, dressing, exercising, getting in and out of bed, and using the toilet. However, Medicare does not cover home-delivered meals, transportation, housekeeping or personal chores services, even if other home health services are being covered.

C. Amount Of Home Health Services Covered

Medicare has special rules as to the amount of skilled nursing care and home health aide services that it covers:

- Skilled nursing care will trigger Medicare home health coverage only if such services are required and prescribed on an "intermittent basis." Once Medicare coverage of home health care is triggered by the need for skilled care, Medicare will also cover home health aide services if they are needed and prescribed on a "part-time or intermittent basis."
- If skilled services other than nursing care trigger the Medicare home health coverage, then Medicare will also cover both nursing and home health aide services if they are needed and prescribed on a "part-time or intermittent basis."

The definitions of and criteria for "part-time or intermittent" have been the subject of much dispute over the years. However, the law now defines "part time or intermittent." Medicare coverage of skilled nursing and home health aide services is limited to a combined total of less than eight hours per day and a combined maximum of 28 hours per week (or, subject to individual case review, a maximum of 35 hours per week). Medicare defines "intermittent" skilled nursing care as being provided or needed fewer than seven days per week, or

less than eight hours per day for a period of no more than 21 days, with exceptions for undefined exceptional circumstances.

> ***EXAMPLE:***
>
> *Dan meets all of the criteria to obtain Medicare coverage of his home health care. Dan's family thinks he needs, and says his doctor has ordered, a total of seven hours of nursing care and home health aide services per day. Dan's family says that he needs this much care six days each week.*
>
> *Dan's family wants to know if Medicare will cover these 42 hours per week (seven hours per day, six days per week) of care. The answer is no. Technically, this does not exceed Medicare's definition of "part-time or intermittent." However, this exceeds the number of hours per week that Medicare will cover. Therefore, even if Dan meets all of the Medicare requirements for home health care coverage, Medicare will not cover this much care.*

III. Cost To Beneficiaries

Home health care is one of the few Medicare covered benefits that requires almost no cost sharing by beneficiaries. There is no deductible and no co-payment, other than a 20 percent coinsurance for durable medical equipment.

IV. Medicare Payment For Home Health Care

Prior to October 1997, home health agencies (HHA) were reimbursed by Medicare on a fee-for-service basis, based on the reasonable cost of providing services. However, Medicare home health payments skyrocketed over the past decade, in part due to restrictions on inpatient care, a growing senior population, and advocacy efforts on behalf of

beneficiaries. Also, the U.S. General Accounting Office (GAO) had issued reports of widespread fraud and abuse including improper billing and inflation of costs by HHAs. The GAO concluded that the payment system for home health care allowed much room for such improprieties. Prior to the implementation of a prospective payment system (PPS), discussed in the next section, an interim payment system (IPS) was in effect between 1997 and 1999.

A. Prospective Payment System (PPS): Effective 10/00

Since October 1, 2000, Medicare has paid for home health services under a prospective payment system (PPS). Under the new PPS, before a HHA provides care to a Medicare patient, the HHA must perform an initial assessment. The requirements for the initial assessment are contained in a very specific assessment tool called the Outcome and Assessment Information Set (OASIS). Thus, the initial assessment is referred to as an OASIS assessment. Based on the outcome of the OASIS assessment, the patient is assigned one of four clinical severity levels, one of five functional severity levels, and one of four service utilization severity levels. The patient's clinical, functional and service utilization severity levels are combined to assign a "home health resource group" or "HHRG" to the patient. The HHRG determines how much Medicare pays the HHA for that patient's care.

Under the new PPS, Medicare payment is made based on a 60 day episode of care. Therefore, the PPS requires that the beneficiary's physician review the plan of care every 60 days. During the last five days of each episode of care, a new OASIS assessment must be completed and a HHRG reassigned. The care plan must be reviewed sooner than 60 days if the beneficiary changes HHA, there is a significant change in the beneficiary's condition that would result in a different HHRG being assigned, or the beneficiary has been discharged from the HHA's care but has returned to the HHA within that 60 days.

The Medicare payment for each 60 day episode of care is payment in full for all home health costs and services except durable medical equipment and certain osteoporosis drugs. Medicare will still pay separately for these exceptions. However, if the HHA provides other services (such as physical therapy) through a different provider, the HHA must cover such services from its Medicare payment for that episode of care.

There is no limit on the length of time that a beneficiary may receive Medicare covered home health care. Also, HHAs are required to provide advance written notice if they believe Medicare coverage will be denied. This is now being referred to as "Advance Beneficiary Notice" or an "ABN."

When providing a beneficiary with an ABN, HHAs must use a standard form that is provided by the Medicare program. An ABN must be given in the following situations: (a) when an HHA tells a beneficiary that Medicare will not pay for the home health services; (b) when an HHA is going to reduce a beneficiary's home health services because it believes they will no longer be covered by Medicare; and (c) when an HHA is going to stop providing home health services to a Medicare beneficiary because it believes Medicare will no longer cover the care.

Beneficiaries still have the right to insist that a claim for Medicare coverage be submitted. A Medicare claim submitted at the beneficiary's request (rather than submitted automatically by the HHA) is referred to as a "demand bill." It is important that a demand bill be submitted, or there will be no chance of Medicare payment. If a demand bill is approved, Medicare will pay for the home health services. If a demand bill is denied, then the beneficiary will have something to appeal. Without a denial, there can be no appeal to try to obtain Medicare coverage. Beneficiaries' appeal rights are discussed in the Chapter Six, entitled "Medicare Claims and Appeals."

V. Advocacy Tips

A. Overcoming Some Common Barriers To Medicare Coverage Of Home Health Care

1. Physician Unfamiliarity with Medicare Rules

The treating physician's role in obtaining Medicare coverage of home health care is critical. However, many physicians are not familiar with Medicare's home health care coverage criteria.

Advocates should make certain that the treating physician knows all of the items that must be included in the patient's written treatment plan and that the physician develops an appropriate plan of care.

2. HHA Reluctance to Submit Medicare Claims

A HHA is under financial pressure to make correct Medicare coverage determinations before any claims are sent to the intermediary. If the agency submits too many claims which are denied, it is penalized financially. Therefore, an HHA is often conservative in its assessment of whether a patient qualifies for Medicare coverage of home health care, as well as reluctant to submit claims if Medicare's requirements are not clearly met.

There are two important protections for beneficiaries if an HHA believes that Medicare will not cover the beneficiary's home health services and/or does not voluntarily submit a Medicare claim.

a. Advanced Beneficiary Notice (Written Notice of Non-Coverage)

An HHA is required to give a Medicare beneficiary a written notice, called an Advance Beneficiary Notice (ABN,) if it believes that Medicare will not cover the home health services requested. The ABN must advise the beneficiary that the HHA believes Medicare will not cover the services provided and the basis for that belief. The beneficiary is NOT financially

responsible for home health care services rendered by a Medicare-certified HHA prior to being given the ABN.

b. No-Payment Claims or Demand Bills

If an HHA provides an Advance Beneficiary Notice or otherwise advises the client that Medicare will not cover the home health care, a beneficiary has the right to insist that the HHA nevertheless submit a claim for Medicare coverage. A home health claim that is submitted at the request of the beneficiary (in contrast to a claim at the HHA's initiative) is referred to as a "no-payment claim" or a "demand bill."

It is very important that a beneficiary request that a demand bill be submitted. If a claim is NOT submitted, there can be no formal Medicare determination of coverage nor any formal Medicare denial that can then be appealed. The appeals process is discussed in Chapter Six on Claims and Appeals.

Unfortunately, having a demand bill submitted does not allow the beneficiary to delay paying the HHA. Once the HHA has provided an ABN, the HHA may require that a Medicare beneficiary pay in advance for any care rendered.

3. Some Common but Inappropriate Reasons for Denial of Home Health Care Coverage

REASON GIVEN: The patient needs home care over a long period of time.

Actual Rule: Medicare must pay for home health care for as long as it is medically necessary. There is no legal limit on how long a beneficiary can receive coverage.

REASON GIVEN: The patient's condition will not improve.

Actual Rule: Medicare must pay for home health care if it prevents deterioration of the patient's condition.

REASON GIVEN: The patient has a particular health condition.

Actual Rule: Medicare must cover home health care based on the services the individual beneficiary needs, not on what type of disease or injury she/he has.

REASON GIVEN: The patient has family members living in the home who could provide the care with or without training.

Actual Rule: Medicare cannot deny payment on the basis that there is someone at home who could provide care, if that person is not willing to do so.

B. General Advocacy Tips

There are quite a few steps that advocates can take on behalf of beneficiaries who may be experiencing improper denial of home health care services. These include:

Check with the treating physician. The treating physician is the one who should be directing treatment through the HHA. If the treating physician supports the need for home health care, ask him/her to write an order for continued services and ask him/her to NOT sign any discharge order requested by the HHA.

Contact another doctor. If the beneficiary's physician is not willing to be supportive, another doctor may be willing to order the home health care services the beneficiary needs.

Contact the HHA and object to the denial, reduction or termination. Insist that the HHA provide or continue to provide the services ordered by the beneficiary's doctor. Request that the agency provide in writing with the reason for the reduction, termination or denial. Advise the HHA that they will be sent a letter reflecting why the reduction, termination or denial is improper, and send such letter if necessary.

Ask the HHA to hold a meeting with the beneficiary and his/her family prior to the reduction or termination. Advocates should participate in

such a meeting if possible. It will be much more difficult for the HHA to carry through with its intent to deny Medicare covered services when faced with the people affected by its actions and people who are familiar with the coverage rules and the appropriateness of the intended action.

Be familiar with the Medicare rules and standards for coverage of home health care. This will put both the advocate and the beneficiary in a much stronger position to counteract any wrong information or advice given by the HHA as to coverage.

Chapter 4
Medicare Part B Benefits

I. Part B Benefits

A. Covered Benefits Generally

Medicare Part B, also referred to as Medical Insurance, generally covers physician and outpatient medical services. Outpatient medical services include outpatient hospital services (e.g., emergency room visits, outpatient clinics and outpatient surgery), physical and occupational therapy, speech pathology services, durable medical equipment, ambulance services, clinical laboratory tests and treatments, and outpatient psychiatric services.

B. Exclusions From Coverage

Medicare Part B does not provide comprehensive coverage. It specifically excludes a number of services and covers only very limited routine or preventive care as discussed in the following section. Other than the limited preventive care that Medicare covers, all medical care must be medically reasonable and necessary for the diagnosis or treatment of illness or injury for Medicare to cover it.

Medicare Part B specifically does not cover the following:

- dental care;
- routine physical examinations;
- outpatient prescription drugs (except when they cannot be self-administered and certain oral cancer drugs);
- routine foot care;

- routine eye examinations (i.e. refractions);
- hearing aids; and
- eyeglasses (except one pair of glasses or lenses following each cataract surgery).

C. Covered Preventive Services

The Balanced Budget Act of 1997 (known as "BBA") added a number of preventive benefits to Medicare coverage. Some additional preventive benefits were added by the Benefits Improvement and Protection Act of 2000 (commonly called "BIPA") and the Medicare Modernization Act of 2003 (known as "MMA"). These benefits greatly increase the number of exceptions to the general rule that Medicare does not cover preventive care. Each of the preventive benefits added along with any restrictions, is described below.

1. "Welcome to Medicare Physical"

All new Medicare beneficiaries who first enroll in Part B after January 1, 2005, can receive a preventive physical exam within the first six months of having Medicare Part B. This benefit applies both to beneficiaries who are younger than 65 and those older than 65. The physical must be received no later than six months after Part B first begins in order to be covered by Medicare, and must be performed by a doctor, doctor's assistant, nurse practitioner, or clinical nurse specialist.

The exam includes measurement of height, weight, and blood pressure and an electrocardiogram. It also includes education, counseling and referral for other preventive services covered by Medicare. The physical exam benefit does not cover payment for lab tests.

Like most Medicare Part B services, Medicare will pay 80 percent of the Medicare-approved amount for the physical exam services after beneficiaries have met their Part B deductible. Beneficiaries or their supplemental insurance will be responsible for the other

20 percent. People who are enrolled in a Medicare Advantage plan, will need to check with their plan about any co-payments required for the exam.

NOTE: *The annual deductible and co-insurance amounts are discussed later in this chapter.*

2. Blood Screening Tests For Cardiovascular Disease

Effective January 1, 2005, this benefit promotes early detection of cardiovascular disease among people who have not yet shown any signs or symptoms of the disease. The benefit provides cholesterol and blood lipid screening tests once every two years. The tests are free as long as they are ordered by a doctor, and they are not subject to the Part B deductible or co-payments.

The screening tests include a cholesterol test to measure a person's total cholesterol level, HDL cholesterol level, and triglyceride level, and are performed after a 12-hour fasting period. Other blood tests used to detect signs of an elevated risk for cardiovascular disease may be covered pending Medicare approval.

3. Screening Mammography

For woman age 40 and older, Medicare covers an annual mammogram with no Part B annual deductible, however the 20 percent co-insurance applies, or co-insurance. Women between the ages of 35 and 39 can get one baseline mammogram. Medicare also covers new digital technologies for mammogram screening.

4. Screening Pap Smear and Pelvic Exam

Medicare covers a pelvic exam including a clinical breast exam and a pap test. Medicare covers this benefit on an annual basis for women at high risk for cervical or vaginal cancer. For those women not in the high-risk category, Medicare will cover a pelvic exam and pap test once every two years. These services are covered in full, with no beneficiary co-insurance or annual deductible.

5. Prostate Cancer Screening Tests

Medicare covers an annual prostate cancer screening consisting of a digital rectal exam and a prostate-specific antigen (PSA) blood test. This is covered for men age 50 and older. The annual deductible and 20 percent co-insurance applies to the digital exam but the PSA blood test is covered in full.

6. Colorectal Screening

Medicare covers certain tests used to screen for colorectal cancer. For those age 50 and older, Medicare covers a screening fecal-occult blood test once every year, and a screening flexible sigmoidoscopy once every four years. For those at high risk for colorectal cancer, Medicare also covers a screening colonoscopy once every two years. For those who are not at high risk for colorectal cancer, Medicare will cover a colonoscopy once every ten years, but at least every four years must have passed since a previous screening flexible sigmoidoscopy. In addition, Medicare covers other tests and procedures as CMS determines to be appropriate. A barium enema may be substituted for a flexible sigmoidoscopy or a colonoscopy if the physician certifies that the results will be as conclusive.

For screening flexible sigmoidoscopies and screening colonoscopies that are covered by Medicare as an outpatient procedure, the beneficiary co-insurance is 25 percent of the Medicare approved amount and the annual deductible applies.

7. Diabetes Self-Management

Medicare covers diabetes outpatient self-management training services as well as blood-testing strips and blood glucose monitors for those with diabetes. This coverage is for those who do not use insulin as well as those who do use it. Coverage of blood glucose monitors includes the lancets, reagent strips and other supplies necessary for the proper functioning of the monitor.

In order to obtain Medicare coverage for these items, the prescription must meet very specific requirements:

- the item(s) must be prescribed by the physician treating the diabetes;
- the prescription must specify the number of strips to be dispensed;
- the prescription must specify whether or not the patient is being treated with insulin injections;
- the prescription must specify the frequency with which the beneficiary should use the supplies (it may not provide for use "as needed"); and
- the prescription may not be for more than six months at a time.

Since January 1, 2002, medical nutrition therapy services are covered for those who have diabetes or renal disease who have not had diabetes outpatient self-management training within a certain time period. Medicare covers three hours of such services for the first year, and up to two hours in subsequent years. The beneficiary co-payment will be 20 percent of the Medicare approved amount and the annual deductible applies.

As of January 2005, Medicare also covers up to two diabetes screening tests per year for beneficiaries at high risk for diabetes. The tests are free as long as a beneficiary has a referral from a physician, and they are not subject to the Part B deductible or co-insurance.

8. Bone Mass Measurements

Certain procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the procedure's results, are covered if the test is ordered by the physician or qualified non-physician practitioner who is treating the beneficiary.

If all of the criteria for coverage are met, Medicare will cover a bone mass measurement once every two years. Medicare may cover it more often if medically necessary, such as for monitoring an individual on long-term glucocorticoid (steroid) therapy for more than three months, or for performing a baseline bone mass measurement to permit monitoring of the individual in the future. The annual deductible and 20 percent co-insurance amounts apply.

9. Screening for Glaucoma

Since January 1, 2002, Medicare covers an annual glaucoma screening for three categories of individuals: (a) those at high risk for glaucoma; (b) those with a family history of glaucoma; and (c) those who have diabetes. The annual deductible and 20 percent co-insurance amounts apply.

10. Shots (Vaccinations)

One Flu shot per year is covered for Medicare beneficiaries. One Pneumococcal Pneumonia shot is covered per patient. There is no co-insurance or deductible for these shots if the provider accepts assignment. Hepatitis B shots are covered for beneficiaries of medium to high risk of Hepatitis B. The Co-insurance for this shot is 20 percent of the Medicare approved amount, after the yearly Part B deductible is met.

II. Beneficiary Costs For Part B Benefits

A. Deductibles And Co-insurance In General

There is an initial, annual deductible for Medicare Part B benefits. In addition, Medicare generally pays 80 percent of the Medicare-approved amount. (For certain types of services, however, Medicare pays 100 percent of the approved amount). Beneficiaries are generally responsible for 20 percent of the Medicare-approved amount; this 20 percent is called the "coinsurance amount" or "co-payment." In many cases, beneficiaries are also responsible for amounts above

the Medicare-approved amount. However, in other cases, there are limits on how much beneficiaries may be required to pay. Such limits are discussed below. Beneficiaries' costs for Part B services are also contained in a chart at the end of the first Chapter, "Medicare Overview."

B. Co-insurance And The Concept Of "Assignment"

Assignment is an agreement by the health care provider to accept as payment in full the amount Medicare approves for Medicare-covered services. In such cases, beneficiaries are responsible only for the 20 percent co-insurance (plus any part of the annual deductible that has not yet been paid). When a service is provided "on assignment," Medicare makes its payment directly to the provider and the provider may not charge the beneficiary anything beyond the annual Part B deductible and the 20 percent co-insurance.

1. Participating and Nonparticipating Physicians

Some physicians and suppliers contract with Medicare to accept assignment on all claims. Such providers are called "participating" physicians. Participating physicians have distinct advantages: their names are placed in a Medicare Directory of Participating Physicians and Suppliers, commonly referred to as "MEDPARD," which is available to Medicare beneficiaries; they are paid directly by Medicare on an expedited basis; and the Medicare-approved amount for their services is slightly higher than for services provided by non-participating physicians and suppliers.

A copy of the MEDPARD for various parts of California may be obtained from the Medicare Part B carrier's, National Heritage Insurance Company (NHIC), Web site at **www.medicarenhic.com**, or by calling 1-800-MEDICARE or visiting **www.medicare.gov**.

Even if a physician is not a participating provider, he or she may accept assignment on a claim-by-claim basis. Therefore, a beneficiary who goes to a non-participating physician should still

ask that physician to take assignment. Physicians who DO take assignment cannot collect the full charge up front. They can only collect the 20 percent co-insurance that Medicare does not pay.

Beneficiaries should be aware that, even if their primary physician accepts assignment, they may be referred to specialists and other providers who do not.

C. Unassigned Physicians' Claims

1. Limiting Charge

Medicare limits the amount that a physician who does not take assignment may charge a Medicare beneficiary. This is called a "charge limit," or "limiting charge." It is important to remember that the limiting charge does not apply to all Medicare Part B claims. It does apply to anything billed by a physician, to supplies commonly supplied by a physician, and to charges by independent practicing physical or occupational therapists.

The cap for all physician services is a maximum of 15 percent above the Medicare-approved amount. To calculate the limiting charge for services rendered, simply multiply the Medicare-approved amount by 1.15.

2. Ensuring That a Beneficiary Pays No More Than the Limiting Charge

When a provider does not accept assignment on a claim, Medicare pays the beneficiary, who is then responsible for paying the provider. The provider may legally collect payment from the beneficiary before Medicare processes the claim. However, in order to protect against overcharges, if at all possible beneficiaries should wait until they receive the Medicare Summary Notice (MSN) form before paying a bill. A sample MSN is provided at the end of this chapter and may be found at **www.medicare.gov**.

The MSN should advise the beneficiary of the total he or she owes, taking into account any assigned charges and the limiting charge on any unassigned charges. If a doctor insists upon payment at the

time of service, the beneficiary should ask the provider to submit the claim immediately to Medicare, and review the MSN when it arrives to make sure that he or she did not pay too much.

SAMPLE PHYSICIAN LIMITING CHARGE

	With Assignment	Without Assignment
1. Doctor's Bill	$125	$125
2. Medicare-approved amount	$100	$100
3. Amount Medicare pays (80% of approved amount)	$80	$80
4. Beneficiary co-payment (20% of approved amount)	$20	$20
5. Maximum physician may charge	$100[1]	$125[2]
Total Beneficiary Pays[3]	**$20**	**$35**

1. The maximum a physician may charge on an assigned claim is the Medicare-approved amount.
2. The maximum a physician may charge on an unassigned claim is 15 percent above the Medicare-approved amount.
3. The total amount for which the beneficiary is responsible is the difference between the maximum the physician may charge and the amount Medicare pays.

3. Non-Emergency Surgery

Physicians who do not accept assignment for non-emergency surgical procedures for which they charge $500 or more must provide the beneficiary advance written notice of the following:

- the estimated actual charges for the procedure;
- the estimated Medicare-approved charges;

- the excess of the physician's actual charges over the approved charges; and
- the estimated amount the beneficiary will owe.

> ***EXAMPLE:***
>
> *Jeff B. went to his doctor on May 15, 2005, complaining of stomach pains. His doctor did not accept assignment and charged Jeff $150; Medicare approved only $100. Because of the limiting charge rule, the maximum the doctor could legally charge or collect from Jeff is a total of $115 (15 percent above $100 or $100 x 1.15). In this case, Medicare will pay $80 and Jeff B. will be responsible for the 20 percent co-payment ($20) plus the 15 percent above the approved amount ($15), for a total of $35.*

If a physician has not provided the beneficiary with this information in writing prior to rendering the non-emergency surgery, the physician may not collect (or must refund) any amount in excess of how much Medicare approves. In essence, this means that if advance notice is not provided, the physician must accept assignment. For purposes of this rule, any surgery that can be scheduled in advance is considered non-emergency surgery. Even if a physician has given proper advance notice, the limiting charge still applies.

C. Clinical Laboratory Tests

Assignment must be accepted for all clinical diagnostic tests including those performed by independent clinical laboratories, hospital laboratories, and physicians' offices.

For clinical laboratory services, Medicare pays 100 percent of the Medicare-approved amount and beneficiaries are not assessed any

deductibles or co-insurance. Therefore, providers should not require payment from beneficiaries for any clinical diagnostic tests.

D. Ambulance Services

There are strict guidelines for Medicare coverage of ambulance transport. Medicare only covers ambulance transport when it is considered reasonable and medically necessary and the patient cannot travel safely by any other means. Skilled services are usually required to validate the need for ambulance transport. If these general guidelines are met, Medicare can cover certain non-emergency transports: if a non-emergency transport is "scheduled" an attending physician must pre-authorize the trip through a written order; if a non-emergency ambulance trip is not "scheduled", the trip does not have to be pre-authorized (but if a beneficiary resides in a facility and is under the care of a physician, the physician must certify that the trip was medically necessary within 48 hours after the transport). Note that Advance Beneficiary Notices (ABN), a written statement from a provider notifying a beneficiary that a particular service may not be covered by Medicare, are rarely used for ambulance trips.

In April 2002, a new ambulance fee schedule became effective for ambulance services. All ambulance providers who bill Medicare must take assignment. The fee schedule is transitional with full compliance effectively commencing January 1, 2006. The fee schedule for California is available at the NHIC Web site at **www.medicarenhic.com.**

The requirements for Medicare coverage of ambulance services and the types of service covered are available at the CMS Medicare Ambulance Services Web site: **www.cms.hhs.gov/suppliers/ambulance.**

E. Rules For Particular Types Of Services

1. Hospital Outpatient Services

The amount that Medicare beneficiaries have been required to pay for hospital outpatient services has always differed from the 20 percent co-insurance they must pay for other types of Part B services. For most Part B services, as discussed earlier in this chapter, beneficiaries pay 20 percent of the Medicare approved amount. However, for hospital outpatient services, Medicare beneficiaries have always been required to pay 20 percent of the amount the hospital charges, without regard to the Medicare approved amount and without any limits as to how much may be charged. This has resulted in beneficiaries paying far more than 20 percent of the total amount the hospital received as payment for Medicare outpatient services.

This problem was addressed in the Balanced Budget Act of 1997 and more recently in the Balanced Budget Refinement Act of 1999. Beneficiaries now pay a percentage of the costs that Medicare pays the hospital, but the rate of payment depends on which hospital a beneficiary goes to and which services are received. Effective January 1, 2000, the beneficiary coinsurance for each hospital outpatient service can be no more than the Part A inpatient hospital first day deductible (which is $912 in 2005). Thus, in 2005, the beneficiary coinsurance for each hospital outpatient service can be no more than $912. If at all possible, beneficiaries should ask their providers and the hospital what their coinsurance amount will be prior to receiving outpatient services.

2. Outpatient Psychiatric Services

Medicare pays less for outpatient psychiatric services than it does for other physician services. Medicare pays only 50 percent of the Medicare approved amount for outpatient psychiatric services, even though it pays 80 percent of the Medicare approved amount for other types of physician services.

If the provider accepts assignment for outpatient psychiatric services, then the beneficiary must pay 50 percent of the Medicare approved amount. If the provider does not accept assignment, then the beneficiary must pay the 50 percent co-insurance plus an additional 15 percent above the Medicare approved amount. This additional 15 percent is referred to as the limiting charge. The concepts of assignment and limiting charge are discussed earlier in this chapter.

3. Physical and Occupational Therapy

There is currently no limit to the dollar amount that Medicare will pay for covered therapy services each year. Prior to the year 2000, Medicare did have a limit of about $1,500 each for physical and occupational therapy. For the years 2000 – 2002 and from January through August of 2003, that limit was dropped. During that time period, CMS studied the issue of payment for such therapy and recommended a payment policy to Congress, including instituting a new cap on how much therapy Medicare will cover. Effective September 1, 2003, Medicare limited coverage for outpatient physical therapy, speech-language pathology, and occupational therapy to $1,590 per year for physical therapy and speech-language pathology combined, and $1,590 per year for occupational therapy. The Medicare Modernization Act of 2003, however, lifted the therapy cap as of December 8, 2003, this time indefinitely.

F. Private Contracts With Physicians To Pay Outside Of Medicare

Since January 1, 1998, in very limited circumstances, a physician may enter into a "private contract" with Medicare beneficiaries to charge higher amounts for services than would be allowed by Medicare's balance billing limits. The idea behind allowing such private contracts is that physicians should be allowed to charge beneficiaries higher amounts if the beneficiaries are willing to pay them.

The requirements that a physician must meet in order to enter into a private contract are complicated and quite detailed. Essentially, however, a physician and beneficiary who enter into a private contract agree that no claims will be submitted to Medicare for a period of two years, and that during those two years, the Medicare beneficiary will pay whatever the physician decides to charge for his or her services. Another way of describing this is that the physician has chosen to "opt out" of Medicare. The private contract applies to all services by that particular physician, i.e. the physician must opt out of Medicare for all patients for a period of two years. However, a private contract with one physician does not apply to services a beneficiary may receive from other physicians.

1. Who May "Opt Out" of Medicare Through a Private Contract

The option of private contracting applies to "physicians" and to "practitioners." Each of these terms has a very specific meaning in Medicare. The term "physicians" includes doctors of medicine and osteopathy. The term practitioners includes: physician assistants; nurse practitioners; clinical nurse specialists; certified registered nurse anesthetists; certified nurse midwives; clinical social workers; and clinical psychologists. Thus, any one of these types of providers may enter into a private contract with his/her Medicare patients and opt out of Medicare.

For purposes of private contracting the following types of providers do NOT fall within the Medicare definition for physician or practitioner: chiropractors; podiatrists; dentists; oral surgeons; and physical and occupational therapists in independent practice. Thus, these types of providers may not opt out of Medicare by entering into a private contract with their patients.

2. Requirements for a Private Contract

In order for a private contract to be valid, a number of different requirements must be met. The private contract must be in writing, signed by both the doctor and the beneficiary, and advise

the beneficiary, in easy to understand language, a list of very specific information.

In addition, a physician who wishes to enter into a private contract must, within ten days of entering into the first private contract, file an affidavit with the Medicare carrier obligating the physician not to submit any claim or seek any payment from the Medicare program for any patient for a period of two years.

A physician or practitioner may not require a Medicare beneficiary in an emergency or urgent situation to enter into a private contract in order to receive care.

3. Services Covered by a Private Contract

As a general rule, a physician or practitioner who chooses to opt out of Medicare (by entering into private contracts) must do so for all services for all patients for a period of two years.

If a physician (or practitioner) chooses to opt out of Medicare and enters into a private contract with his/her patients, that private contract applies to all services or items provided by that doctor (or practitioner). A provider cannot choose to privately contract for some types of services but not other types of services. Likewise, a provider can not choose to privately contract for services rendered in one location or geographic area, but not for services rendered in another location or geographic area.

Similarly, a doctor (or practitioner) who chooses to enter into a private contract with one Medicare patient must do so for all of his/her Medicare patients. A doctor may not privately contract with some patients, and submit claims to Medicare for other patients. A doctor who has opted out of Medicare may not even treat a Medicare Advantage plan enrollee unless the doctor enters into a private contract with that enrollee. These restrictions make it less likely that a doctor or practitioner would be able to afford to opt out of Medicare, especially if his/her patients include a large number of Medicare beneficiaries.

There are only two exceptions to the seemingly unlimited scope of a private contract. First, physicians may provide services to Medicare beneficiaries who have enrolled in a Medical Savings Account (see the chapter on Medicare Advantage) without entering into a private contract with those beneficiaries. Second, a physician who has opted out of Medicare may still provide emergency care or urgent care to a Medicare beneficiary without entering into a private contract with that beneficiary.

4. Effect of Private Contracting on Beneficiaries

A beneficiary who enters into a private contract with a physician or practitioner will undoubtedly experience an increase in out of pocket costs. Neither Medicare nor Medicare supplemental insurance will pay for any services rendered by a doctor who has entered into private contracts with his/her patients. Furthermore, there is no limiting charge or any other cap on how much a doctor can charge beneficiaries who have entered into a private contract. Private contracting could be extremely expensive for beneficiaries. If cost is a factor for beneficiaries, private contracting could act as a barrier to their access to care. Fortunately for beneficiaries, relatively few doctors have chosen to opt out of Medicare.

G. Waiver Of Liability

As discussed above, services must be "medically reasonable and necessary" in order to be covered by Medicare. When claims are denied by Medicare on the grounds that the services were not medically reasonable and necessary, "waiver of liability" provisions may protect beneficiaries from having to pay for such services.

In order for a beneficiary's liability for the payment of a service to be waived, all of the following criteria must be met:

1) Medicare payment was denied because Medicare determined that the service was not reasonable and necessary for the diagnosis or treatment of an illness or injury;

2) The medical provider must have accepted assignment on the claim (however, for physicians it does not matter if assignment was accepted); and

3) The beneficiary did not know or could not reasonably have been expected to know that the services would not be covered.

If all of these conditions are met, liability for the charges will shift either to the provider or, if the provider could not reasonably be expected to have known that Medicare would not pay for such services, to the Medicare program. In either case, the beneficiary would not be liable for payment.

Beneficiaries may not use the waiver of liability provisions to avoid paying for items and services that are specifically excluded from Medicare coverage, such as routine physical examinations, eyeglasses, and long term care.

When a claim is denied by the carrier as not reasonable and necessary, the Medicare Summary Notice (MSN) form should advise the beneficiary that waiver of liability protections may apply. If the denied claim was not taken on assignment, the MSN will have remarks which instruct the beneficiary to contact the carrier if he or she has paid the claim and had no advance knowledge that it would be denied by Medicare. If the claim was taken on assignment, the MSN will inform the beneficiary that he or she cannot be held financially responsible for the denied charges.

[This Page Intentionally Blank}

Chapter 5
Medicare Advantage Plans

I. Introduction
A. Background

Throughout the more than 30 years of Medicare's operation, spending on the program has increased dramatically, from less than $4 billion in 1967 to more than $297.2 billion in 2004. Although Medicare's costs have grown more slowly than the medical care costs for the general population, Congress has still been trying to find ways to reduce Medicare spending or at least slow down its growth.

In 1972, Health Maintenance Organizations (HMOs) were the first type of private insurance plan allowed to contract with the Medicare program and provide Medicare covered services to beneficiaries. Congress believed that having more Medicare beneficiaries in managed care would help accomplish its goal of reducing Medicare spending. Thus, in the Balanced Budget Act of 1997, Congress enacted a new program called Medicare + Choice that expanded the options of private health plans to include: preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private-fee-for-service plans (PFFS), and Medical Savings Accounts (MSAs). In California, HMOs have been the primary kind of private health plan available.

The Medicare Modernization Act of 2003 (MMA), renamed the Medicare + Choice program to "Medicare Advantage" (MA), and created:

- regional PPOs whose coverage areas are comprised of individual states or groups of states; California makes up one regional area;
- Special Needs Plans (SNPs) that are targeted to beneficiaries who are institutionalized, have a severe disabling condition, and/or have Medicare and Medi-Cal; and
- Medicare Advantage prescription drug plans (MA-PDs) that will go into effect in January 2006.

A common element in most of the Medicare Advantage options is that the plans contracting with Medicare receive a predetermined monthly payment for each enrolled beneficiary. This amount is known generally as the capitation rate. Some plans, such as the SNPs that are serving beneficiaries with higher health care costs and the MA-PDs that are also providing the Medicare Part D benefit will receive higher capitation rates than those plans serving the general Medicare population or those not offering prescription drug coverage through Part D. However in general, the same type of plans will receive a monthly fee for each enrollee, regardless of whether the enrollee receives no care or receives a great deal of care.

Plans with annual or projected costs that are below Medicare's monthly capitation rate must distribute the savings to beneficiaries. Plans can do this by offering lower plan premiums and co-payments, additional benefits, strengthened provider networks, a reduction in Part B premiums, or a contribution to a reserve fund.

B. Current Medicare Options

Medicare beneficiaries can choose the traditional fee-for-service system, which is now being referred to as "Original Medicare" or they can enroll in a Medicare Advantage plan offered where they live. Beneficiaries who have enrolled in a Medicare Advantage plan may not use Original Medicare while enrolled in the MA plan. However, all Medicare Advantage plans are required to provide, at a minimum, all of the benefits covered in the Medicare fee-for-service system. A full description of Medicare covered benefits is contained in earlier

chapters regarding Medicare Part A and Medicare Part B. With the exception of cost plans and some retiree coverage offered through HMO plans, all Medicare HMOs that offer drug coverage in 2005 must offer the Medicare Part D benefit in 2006 (i.e. offer a Medicare Advantage Prescription Drug plan, or "MA-PD"). These plans offering Part D benefits will be paid a higher monthly capitation rate per enrollee than those plans not offering Part D.

C. Scope Of This Chapter

This chapter discusses the advantages and disadvantages of Medicare Advantage plans, the rules for enrollment and disenrollment, how various MA plans work and some protections for beneficiaries enrolled in MA plans. The rights of Medicare Advantage enrollees to appeal or challenge MA decisions with which they do not agree are discussed in Chapter Six on Claims and Appeals.

II. Eligibility, Enrollment And Disenrollment

A. Eligibility

Medicare beneficiaries must have both Medicare Part A and Medicare Part B in order to enroll in a Medicare Advantage plan. Beneficiaries who have Medicare either on the basis of age (they are age 65 or older) or disability (they have received Social Security Disability Income for at least two years) are eligible to enroll in a MA plan. This is true even if a beneficiary has a terminal illness and has elected to receive hospice care.

Beneficiaries who have end stage renal disease (ESRD) are not eligible to enroll in a Medicare Advantage plan. However, if a Medicare beneficiary already is enrolled in a plan and then develops ESRD, the plan cannot disenroll that person. In addition, if a person developed ESRD while a member of a commercial managed care plan that also offers an MA product, that person may have a right to transition into the MA plan either when first becoming eligible for Medicare

or at a later time as long as that person has had no break in coverage between the commercial plan and the MA plan.

> ***EXAMPLE:***
>
> *John, age 64, developed ESRD while he was a member of Happy Valley HMO, which he still has through his current employment. When John turns 65 and becomes eligible for Medicare, he can enroll in Happy Valley's Medicare Advantage (MA) product, even though he has ESRD.*

MEDICARE BENEFICIARIES WHO MAY ENROLL IN MEDICARE ADVANTAGE	
Age 65 or older	Yes
Disabled	Yes
ESRD	No[1]
Hospice	Yes

1. See narrow exception explained above.

Medicare Advantage plans may not discriminate against any Medicare beneficiary on the basis of that person's current health or health history, with the exception of those with kidney failure (ESRD). A Medicare Advantage plan must accept all eligible beneficiaries who wish to enroll on a first-come, first-served basis if the plan is open to other Medicare beneficiaries and during the Annual Enrollment Period of November 15 through December 31.

B. Enrollment

In the past, beneficiaries have been able to enroll and disenroll from a Medicare managed care plan at any time during the year. Beginning in 2006, beneficiaries will only be able to enroll, disenroll, or change plans once during the first six months of 2006. In 2007 and later, this 'open enrollment period' (OEP) will be shortened to the first three

months of the year. These enrollment restrictions do not apply to people who have both Medicare and Medi-Cal and who are enrolled in a MA-PD (a Medicare Advantage plan that also provides Part D drug benefits). These beneficiaries can still enroll, disenroll, or switch plans on a monthly basis.

1. Enrollment Periods

a. Initial Coverage Election Period (ICEP)

The initial coverage election period (ICEP) is the time when a person newly eligible for Medicare Advantage can make an initial election to enroll in an MA plan offered in their area. This period begins when a person is enrolled in both Parts A and B of Medicare (in other words, if someone delays enrollment in Part B because they have EGHP coverage, the ICEP would not begin until they later enroll in Part B). The length of the ICEP depends upon when someone is first eligible to enroll in an MA plan:

- For people who will be first eligible to enroll in an MA plan before May 15, 2006, their ICEP begins three months prior to the their enrollment in both Parts A and B, and ends the last day of the month before their enrollment in both Parts A and B is effective;
- For people who will be first eligible to enroll in an MA plan after May 15, 2006, the ICEP is the same as their initial enrollment period (IEP) for Part B (3 months before they are eligible, the month of eligibility and three months after, for a total of seven months – see Chapter I).

Note that at the beginning of the Part D Medicare prescription drug program, Medicare beneficiaries will have an Initial Enrollment Period (IEP) to enroll in Part D – see Chapter Twelve. During this time, individuals can make one Part D enrollment choice, including enrollment in a Medicare Advantage – Prescription Drug (MA-PD) plan. In the MA

context, this election period applies only to MA-PD enrollment elections, whereas the ICEP applies to enrollment into any type of MA plan. After May 15, 2006, the IEP for Part B, the IEP for Part D and the ICEP for MA plans (Part C) will all be uniform (3 months prior to the month of eligibility until three months after the month of eligibility, for a total of seven months).

b. Annual Election Period (AEP)

The annual election period (AEP) is the time during which a person can enroll into or disenroll from a MA plan, or can switch from one MA plan to another for the following calendar year. For 2006, the AEP begins on November 15, 2005 and ends May 15, 2006. For 2007 and subsequent years, the AEP will be from November 15 through December 31 of a given year, with the change effective January 1 of the following year.

c. Open Enrollment Period (OEP)

Through the end of 2005, a MA plan may have had an open enrollment period on an on-going basis. Medicare beneficiaries could enroll in or switch enrollment in any Medicare plan at any time. This continuous open enrollment is called an Open Enrollment Period (OEP).

Starting in 2006, however, this OEP changes. In 2006, beneficiaries can only make one enrollment change during the first six-months of the year. For example, a person who is not enrolled in a MA plan, but who is eligible to join one, can only join a plan once during the first six months of the year. Similarly, a person who is already enrolled in a MA plan, can only disenroll from that plan during this time period. After the first six months, beneficiaries who want to disenroll from their plan and/or join another plan, must wait until the Annual Election Period (November 15 – December 31) to make a change that will become effective the first of the following year.

For 2007 and subsequent years, the OEP will shorten to the first three months of the year. As mentioned earlier, however, this restricted OEP does not apply to beneficiaries who have both Medicare and Medi-Cal. They will still be able to enroll, disenroll, or switch MA plans on a monthly basis if that plan also provides their prescription drug benefit. Note: the Open Enrollment Period does not apply to Medical Savings Accounts (MSAs), a type of MA plan described in a later section of this chapter.

Starting in 2006, beneficiaries will have restrictions during the OEP based on the type of plan she/he is enrolled in at the time. The 'type' of plan refers to whether it provides Medicare Part D prescription drug coverage. People who have elected Part D coverage (whether it is a MA-PD or Original Medicare with a stand-alone prescription drug plan [PDP]), can only join or switch to another plan with Part D benefits. People without Part D coverage who are in an MA only plan or Original Medicare without a PDP, can only join or switch to another plan that does not offer Medicare Part D benefits. In other words, beneficiaries cannot move in and out of Part D during this time period.

For example, during the OEP in 2006 and beyond, a beneficiary enrolled in a MA-PD can either

- enroll in another MA-PD, or
- disenroll from his or her plan, return to Original Medicare, and join a stand-alone PDP.

She/he cannot join a MA only plan or return to Original Medicare without enrolling in a PDP. Similarly, a beneficiary in Original Medicare without a PDP, can only join a MA plan without Part D benefits during the OEP.

d. Special Enrollment Period (SEP)

Following certain 'trigger' events, Medicare allows beneficiaries to enroll in or disenroll from an MA plan (including MA-PDs) for a defined time period. This period is called a special enrollment period (SEP). The length of SEPs varies depending on the trigger event. SEP trigger events for MA plans include when:

- A beneficiary involuntarily loses creditable prescription drug coverage or such coverage is involuntarily reduced so that it is no longer considered creditable. (Note: Creditable coverage refers to prescription drug coverage that is at least as good as that provided under Medicare Part D [i.e. through a prescription drug plan (PDP) or a Medicare Advantage prescription drug plan (MA-PD)];
- A beneficiary was not adequately informed about the status of creditable coverage;
- The action, inaction or misinformation by a federal employee causes an erroneous enrollment into or disenrollment from a Part D plan.
- A beneficiary disenrolls from a MA-only or MA-PD plan during the first year of MA plan eligibility;
- An MA, MA-PD, or PDP contract is terminated or is no longer offered in the area in which an individual resides;
- A beneficiary no longer resides in a MA, MA-PD, or PDP service area;
- A beneficiary experiences a substantial breach of contract by his/her plan; and

Other "exceptional circumstances" occur that CMS may deem as eligible for a SEP. Some of these "exceptional circumstances" may include situations involving beneficiaries in long-term care facilities, beneficiaries enrolled in employer plans, and

beneficiaries eligible for the Part D low-income subsidy whose enrollment into a PDP or MA-PD will be facilitated. CMS may establish SEPs on a case-by-case basis, especially when warranted by an immediate exceptional circumstance, such as a beneficiary experiencing a life-threatening condition or illness.

These SEP trigger events are important for beneficiaries to know about and to exercise, especially with the beginning of the more restrictive OEP rules in January 2006. SEPs allow beneficiaries to switch plans at times outside the Initial Election Period, the shortened Open Enrollment Period, and the Annual Election Period.

Rules concerning SEPs for MA-PDs are the same as those that apply to Part D prescription drug plans (PDPs). For a discussion of those rights, see Chapter Twelve on Medicare Part D. People who have both Medicare and Medi-Cal will have an ongoing SEP and can change plans on a monthly basis.

e. Default Enrollment Rules for MA Plans with Part D Coverage (MA-PDs)

The Medicare Modernization Act of 2003 (MMA) provides default enrollment rules for beneficiaries enrolled in MA plans. If a beneficiary is enrolled in a MA plan that offers any prescription drug coverage as of the end of 2005, that individual will be defaulted into the same MA organization's MA-PD plan on January 1, 2006. Yet, this individual will still be able to enroll in a different MA-PD plan if she/he wants to. If a beneficiary is a member of a MA plan that does not offer any prescription drug coverage at the end of 2005 and this insurance company's MA plan(s) for 2006 will only be those that include drug coverage (MA-PDs), she/he will be defaulted into Medicare fee-for-service. Beneficiaries in this situation will still be able to enroll in a MA-PD or a PDP if they choose.

f. Optional and Required Disenrollment by the MA Plan

A MA plan has the option to disenroll an member if:

- Any monthly premium is not paid on time. The plan must demonstrate reasonable collection efforts and compliance with notice requirements.
- The individual has engaged in "disruptive behavior" defined as behavior that "substantially impairs the plan's ability to arrange for or provide services to the individual or other plan members. An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment." (See Title 42, Code of Federal Regulations §422.74). An MA plan must make specified efforts to resolve the problem and may only disenroll the individual after CMS review and approval, or
- The individual provides fraudulent information on his or her enrollment form or permits abuse of his or her MA plan card.

A MA plan is required to disenroll a beneficiary if the individual:

- No longer resides in the MA plan's service area;
- Loses entitlement to Medicare Part A or Part B benefits;
- Dies; or
- Is an individual enrolled in a special needs plan (SNP) who no longer meets the special needs status of that plan.

g. MA Plan Leaves the Geographic Area

For several years, a number of MA plans decided to stop serving Medicare beneficiaries in various geographic areas. Beneficiaries whose MA plan leaves the market may enroll in a different MA plan, if any are available in their geographic area,

or they may decide to use Original Medicare. If a beneficiary wants to use Original Medicare, he or she has the right to purchase certain Medicare supplemental policies without any medical underwriting. These protections are discussed in Chapter Seven. Beneficiaries who want to enroll in a different MA plan may do so during the AEP from November 15 – December 31 with an effective enrollment date of January 1 of the upcoming year. The MA plan must receive the beneficiary's enrollment form before the effective date. As of December 21, 2000, beneficiaries with ESRD who are enrolled in an MA plan that withdraws from the market may, like other MA enrollees, enroll in any other MA plan that is available in their geographic area.

h. Beneficiary Changes Residence

If a MA enrollee moves outside of the geographic area served by the MA plan, that person may switch to any MA plan offered in the area to which the enrollee moves, or to Original Medicare. However, the move must be a permanent one, which for this purpose means that it must be for more than six months.

2. Effective Date of Enrollment and Disenrollment

A beneficiary who enrolls in a Medicare Advantage plan during an open enrollment period will have that coverage effective the first of the following month. For example, a Medicare beneficiary who enrolls in a MA plan on February 5 or on February 25 will have coverage through that plan effective March 1. The same time frames apply to disenrolling from an HMO.

Enrollment and disenrollment applications made during the annual election period (AEP) (November 15 – December 31) are effective as of January 1 of the following year.

All Medicare Advantage plans must accept, on a first-come, first-served basis, any Medicare beneficiaries who wish to enroll. Plans

may not discriminate against beneficiaries on the basis of their health, health history, income, educational level or any other basis, except those beneficiaries diagnosed with ESRD.

3. How to Enroll

Enrolling in a Medicare Advantage plan is very simple. A beneficiary must fill out and sign the plan's enrollment form (called an election form) and submit it to the MA plan. Anyone assisting a beneficiary in filling out an election form must also sign the form and indicate his/her relationship to the beneficiary. Thus, a MA plan marketing representative who helps a beneficiary complete an election form, in most cases, must also sign it (unless some of the beneficiary's information is "pre-filled" on the application by the representative). Beneficiaries may also be able to apply online through the **www.medicare.gov** Web site "Online Enrollment Center," as well as through individual MA plan Web sites if they offer that option. In addition, a beneficiary can apply over the phone by calling a plan directly.

The date of the MA plan election will be the date the election form was submitted to the plan. For example, if an enrollment form is filled out and signed on January 25, but is not received by MA plan until February 5, the election of the MA plan will be considered to be February 5. Thus, an election made on February 5 will be effective March 1.

C. Disenrollment

In the past, beneficiaries have had virtually no restrictions on disenrolling from a MA plan. A beneficiary could disenroll from a plan at any time, and for any reason. Beginning in January 2006, however, beneficiaries will only be able to disenroll from their MA plan:

- once during the OEP (the first six months of the year for 2006 and the first three months of the year for 2007 and beyond),

- once during the AEP (November 15 – December 31 of each year with the disenrollment effective as of January 1 of the following year), and
- after the triggering of a special enrollment period.

A beneficiary who enrolls in a different MA plan will automatically be disenrolled from his/her previous plan. An enrollment form can simply be submitted to the new MA plan. A beneficiary can also disenroll from Medicare Advantage altogether and use the traditional Medicare fee-for-service system. If a beneficiary wishes to do this, the beneficiary should sign a request to disenroll and submit it to his/her MA plan. The beneficiary should make sure to keep a copy and, if possible, obtain a receipt from the MA plan in case of a later glitch with the disenrollment.

During the open enrollment period, a beneficiary who disenrolls from a Medicare Advantage plan will have that coverage terminated effective the first of the following month. For example, a Medicare beneficiary who disenrolls from an HMO on January 10 will no longer be enrolled in that HMO effective February 1. These are the same time frames that apply to enrolling in a MA plan.

During the annual election period, a beneficiary's disenrollment is effective January 1 of the following year.

III. Types Of Medicare Advantage Plans

The type of Medicare Advantage plans that companies may offer fall generally into three categories: managed care plans; medical savings accounts; and private fee-for-service plans. There are several different types of managed care plans:

- health maintenance organizations (HMOs);
- provider sponsored organizations (PSOs);
- preferred provider organizations (PPOs); and

- special needs plans (SNPs).

Each type of Medicare Advantage plan is discussed separately below.

Currently, the most common MA plan available in California is a Medicare HMO. Beginning in 2005, a few counties also had private-fee-for-service plans (PFFS) and Special Needs Plans (SNPs) available. Starting in January 2006, however, additional types of MA plans may be offered. Information on plan options for 2006 will be available in October 2005.

Most Medicare Advantage plans share some common requirements and elements:

- they are all paid a predetermined set amount each month for each enrollee.
- they must provide all Medicare covered benefits. They must meet certain marketing, information disclosure and quality assurance requirements.
- they must provide enrollees a mandated appeals process when they deny care or claims.
- These beneficiary protections are discussed in a separate section, which comes after the following description of the types of MA plans.

A. Health Maintenance Organizations (HMOs)

In California, where more than 30 percent of Medicare beneficiaries and more than 50 percent of the working insured are enrolled in HMOs, most people are already familiar with the concept of an HMO. An HMO is an entity that provides or arranges for a certain range of covered health care services to be provided for a predetermined, capitated (per enrollee) fee. It usually provides services through its contract with a network of medical providers, hospitals and nursing homes.

Each enrollee chooses, or is assigned to, a primary care physician, who acts as a gatekeeper to all specialty care including other doctors' visits, diagnostic tests, surgery and other treatment. This means the enrollee must usually receive a referral from the Primary Care Physician before getting specialty care. Generally, the only time an enrollee can obtain care outside of the HMO network is when it is an emergency, when the enrollee is out of the geographic area and needs urgent care services, or when the enrollee receives pre-authorization from the plan.

Many Medicare beneficiaries prefer HMOs to the traditional fee-for-service system because HMOs often provide additional benefits not covered by Medicare and because HMOs generally require lower cost-sharing by the beneficiary than Medicare alone.

1. HMOs With a Point of Service Option

HMO plans may be offered with or without a point-of-service (POS) option. Unlike the general HMO plan described above, a POS option allows the enrollee to go out of the HMO's network and have the HMO cover a portion of that out-of-plan care. The amount the enrollee pays depends on the point of service option the enrollee chooses for each particular medical service. For example, if the enrollee chooses the HMO system as the point of receiving service, the enrollee generally has little or no cost-sharing. If the enrollee chooses specialty care that is part of the HMO network, but which has not been approved by the HMO, the enrollee generally pays a co-payment based on a percentage of an HMO approved fee. However, if the enrollee goes completely outside of the HMO network, that point of service generally involves a very significant cost to the enrollee.

2. Provider Sponsored Organizations (PSOs)

In most respects, Provider Sponsored Organizations (PSOs) are very similar to HMOs. Like HMOs, under Medicare Advantage they are allowed to contract with the federal government to enroll Medicare beneficiaries. They will be required to provide Medicare

enrollees with all Medicare covered benefits in exchange for the same predetermined capitated monthly fee that Medicare pays to HMOs. A PSO is owned and controlled by groups of doctors and medical providers such as hospitals, nursing homes and home health agencies. In contrast, HMOs are owned and controlled by licensed companies, not medical providers. Both must provide all covered Medicare services.

REMINDER

WHEN COMPARING NEW PLANS AND OPTIONS, REMEMBER THAT THE ORIGINAL MEDICARE FEE-FOR-SERVICE SYSTEM IS STILL AVAILABLE TO ALL BENEFICIARIES.

C. Preferred Provider Organizations (PPOs)

Many people who have been insured through their employment are already familiar with the concept of Preferred Provider Organizations (PPOs). Under an employment-based insurance, a PPO plan may be a form of managed care or it may not, depending on the plan.

However, under Medicare, all PPOs are managed care plans. Like HMOs and PSOs, PPOs that contract with the Medicare program would receive the same pre-determined capitated rate for each Medicare enrollee. PPOs must provide all Medicare covered services through its network of doctors, hospitals and other medical providers.

The key word in Preferred Provider Organization is "preferred." A PPO contracts with a network of providers and, as long as the enrollee goes to a medical provider within that network, the enrollee's cost will be a fixed, pre-set co-payment. However, the enrollee may choose to go outside the PPO network at any time. The PPO will still pay a certain portion, but there are no limits on how much the

providers outside the network may charge, and the enrollee's costs can be significant.

From a beneficiary's perspective, a Medicare PPO will be very similar to an HMO that has a point-of-service option. However, there may be greater freedom in terms of direct access to specialty care in a PPO compared to an HMO.

D. Regional Preferred Provider Organizations

Starting in 2006, through the Medicare Modernization Act (MMA), insurance companies can contract with Medicare as regional PPOs. The regions covered by these PPOs will be comprised of individual states or groups of states. As California will be its own region, any private companies that decide to offer these regional PPOs will be available on a statewide basis and will have uniform benefits statewide. MA plans other than regional PPOs that decide to offer Part D coverage will continue to be available on a local basis.

Regional PPOs are required to establish a single deductible for both Part A and B benefits, as well as two maximum out-of-pocket limits—one for out-of-pocket expenses for in-network Part A and B benefits and one for out-of-pocket expenses for all Part A and B benefits. Regional PPOs are not required to offer Part D benefits, but may choose to do so.

E. Special Needs Plans (SNPs)

The MMA allows MA organizations to offer specialized MA plans to beneficiaries who are institutionalized, entitled to Medicaid (Medi-Cal in California), and/or have a severe or disabling chronic condition(s). These specialized plans are called Special Needs Plans (or SNP). SNPs either exclusively enroll or enroll a disproportionate percentage of special needs individuals. Special needs plans are funded like other MA plans, and must provide the same services.

F. Medical Savings Accounts (MSA)

Although Medical Savings Accounts (MSA) are an option under Medicare Advantage, they are very different than the other MA options. An MSA provides a tax-free account of funds to be used for medical care along with a high deductible health insurance policy.

1. Eligibility

There are additional restrictions on MSA eligibility compared to a managed care plan under Medicare. As with other MA plans, a beneficiary must have both Medicare Parts A and B, but can not have end stage renal disease. In addition, however, a beneficiary is not eligible for a MSA if the she/he:

- is eligible for Medicaid (Medi-Cal in California);
- is receiving Medicare hospice care;
- has had a kidney transplant in the last 36 months;
- is a retired (or the widow or widower of a retired) federal government employee who participates in the Federal Employee Health Benefits Program, Department of Defense employee or Veterans Administration employee;
- has other retirement health benefits; or
- lives outside the United States for more than half the year.

If a beneficiary gets end stage renal disease or enrolls in a Medicare hospice program after obtaining an MSA, this does not affect eligibility for the MSA.

2. Enrollment

An individual may enroll in an MSA only during the Initial Coverage Election Period (ICEP) or Annual Election Period (AEP), and can disenroll only during the AEP or a Special Enrollment Period (SEP). Someone cannot move in or out of an MSA during the Open Enrollment Period (OEP).

3. How an MSA Works

If a beneficiary chooses and sets up an MSA account, the Medicare program will purchase for that person an insurance policy that has been approved as a high deductible policy. Medicare will pay the monthly premiums for that policy up to the monthly capitated amount for MA plans. Health insurance policies offered in conjunction with MSAs must cover at least all Part A (except hospice) services and Part B services, after the beneficiary has met an annual deductible. By law, the annual deductible of the health insurance policy cannot be less than $1,000 or more than $6,000.

In addition to purchasing an MSA policy, the Medicare program will also deposit into the MSA tax-free account the amount of money that equals the difference between the MA capitation rate where the enrollee resides and the cost of the MSA insurance policy. These amounts of money are computed on an annual basis and the appropriate amounts are deposited into the MSA in one lump sum in January, at the beginning of the MSA year.

EXAMPLE – PAYMENTS UNDER AN MSA

In November, 2005, Mrs. Q. enrolls in an MSA plan. The monthly premium for the MSA insurance policy is $400. The monthly capitation rate for a MA plan in Mrs. Q.'s geographic area is $500.

Medicare will purchase the MSA policy for Mrs. Q. Medicare will also deposit into Mrs. Q.'s MSA account the difference between the MA capitation rate and the cost of the MSA insurance policy. This difference is $100 per month, which equals $1,200 per year.

On January 1, 2006, Medicare will deposit $1,200 into Mrs. Q.'s MSA account.

The money in the MSA account is tax-free as long as it is used only for the cost of medical care. This includes medical care costs that are not covered by Medicare, long term care insurance premiums, and COBRA premiums. A beneficiary who has an MSA should obtain IRS Publication 502, which identifies all of the different types of medical expenses, which qualify as tax-free uses of an MSA. A beneficiary may use the money in the MSA account to pay for medical care that is being used to meet the annual deductible. However, if the MSA account balance falls below 60 percent of the annual deductible, the beneficiary is subject to a tax penalty.

Once the beneficiary has met his/her annual deductible under the MSA high deductible insurance policy, the policy will pay 100 percent of the amount that would be approved for the medical services under the original Medicare program. A high deductible plan may have an established provider network and the plan may pay only for care that is obtained from a network provider. A non-network policy may pay for care received from any qualified provider, as long as the care would be covered by Medicare.

G. Private Fee-for-service Plans (PFFS)

Under Medicare Advantage, an organization may offer Medicare beneficiaries an insurance plan that reimburses doctors and other medical providers on a traditional fee-for-service basis established by the plan. This is called a private fee-for-service plan (PFFS). A PFFS must, at a minimum, provide coverage for all Medicare covered care and may, if it chooses, provide coverage for additional benefits.

A PFFS contracts with providers that bill the plan for their services, not Medicare. The PFFS pays providers on a fee-for-service basis according to the plan's contracted rates, which may be more than Medicare would pay. The plan member may be responsible for more or less than 20 percent of the amount Medicare would have paid for the same service, depending on the PFFS plan's negotiated rate.

The PFFS must contract with any provider that can lawfully provide Medicare covered services and agrees to accept the PFFS plan's conditions and terms for payment. Providers that do not contract with the PFFS plan must be paid no less than Medicare would have paid for the same service.

Beneficiaries are usually responsible for the plan's co-payments, and may be billed for up to 15 percent of any charges by non-contracted providers. Medicare pays each PFFS the same capitated rate it pays other MA plans, but the company offering the PFFS may also charge Medicare beneficiaries a monthly premium for the plan. (As with other MA plans, beneficiaries still pay Medicare their monthly Part B premium).

IV. Beneficiary protections

A. Information Medicare Advantage Plans Must Disclose

Medicare Advantage plans must disclose more information than was required of Medicare HMOs prior to the Balanced Budget Act of 1997 (BBA). These disclosure requirements, which apply to all types of MA plans, can be broken down into two categories:

- information that a plan must disclose automatically to each enrollee electing its MA plan as well as annually to all enrollees; and
- information that a plan must disclose when an enrollee specifically requests such information. The disclosure requirements within each of these categories are discussed below.

1. Information That Must Be Disclosed Automatically to New Enrollees and to All Enrollees At Least Annually

All plans must disclose a wide array of information including benefits covered, premiums charged, beneficiary cost-sharing, and grievance and appeals procedures. In addition, plans must

automatically disclose all of the information contained in the chart at the end of this chapter.

2. Information That Plans Must Disclose Upon Enrollee Request

If an enrollee requests it, a MA plan must make available the following information:

- the plan's procedures to control utilization of services and expenditures;
- the number of appeals and the number of grievances filed by enrollees along with the aggregate disposition of such appeals and grievances;
- a summary description of the method of compensating the plan's physicians; and
- a description of the company's financial condition including its most recent audited statement.

3. Termination of Providers

If the affiliation between a MA plan and a contracting provider is being terminated, the plan must try to provide written notice of that termination, regardless of the reason such affiliation is ending, to all of the provider's regular patients. This written notice to enrollees is supposed to be given at least 30 days prior to the effective date of the termination. When a provider contract is terminated and such contract involves primary care physicians, the plan must also notify enrollees who are patients of those primary care physicians.

If an MA plan terminates its contract with a beneficiary's provider, that beneficiary has the right to buy a Medigap policy from the MA company in which the beneficiary is enrolled, if it sells one. If her/his MA plan sells a Medigap policy, she/he has 63 days to buy one, beginning from the time she/he is notified of the termination of the provider's contract. In 2007, the parent company of the MA

plan will be required to sell a guaranteed issue Medigap if the MA plan does not have one available. See Chapter Seven for more information.

4. Termination or Modification of Plan

In recent years, many areas in California have experienced plans pulling out of the market. When MA plans terminate their contract with Medicare there is usually widespread publicity in advance of the actual termination. Beneficiaries may want to make a change in their coverage sooner than it is advisable to do so. Being aware of the notice requirements, protections, and options for beneficiaries helps protect beneficiaries and give them the maximum time to decide among their other health care options.

When a MA plan or CMS decides to not renew the plan's contract with Medicare, written notice must be given to each of the plan's Medicare enrollees. The notice must be given at least 90 days before the plan stops contracting with Medicare. If the decision not to renew was made by the plan, the plan must provide the notice, which must include the following information:

- other MA plans serving the area;
- Medicare supplemental insurance options; and
- the availability of original Medicare.

In addition, the notice must be approved in advance by CMS. Options and protections for Medicare beneficiaries who's MA plan leaves their geographic area are explained in the chapter on Medicare Supplemental Insurance.

The general public must also be informed at least 90 days before the end of it's the HMO's contract with Medicare. This may be done by publishing a notice in a newspaper of general circulation in each community that will no longer be served by the plan.

At the end of the year, if a MA plan decides to stay in a particular service area, but increases beneficiary costs by raising the

premium or adding co-payments, beneficiaries enrolled in that plan have the right to buy a Medigap policy from the MA company in which they are enrolled, if it sells one. Beneficiaries also have this right if the MA plan drops an existing benefit. For MA plans that do sell a Medigap policy, affected beneficiaries have 63 days to buy one, beginning from the time they are notified that one of these changes has taken place. Beginning in 2007 beneficiaries will have the right to a Medigap from the parent company of the MA plan, if there is no Medigap available from the MA plan. See Chapter Seven for more information.

B. Mandated Standards

Medicare Advantage plans must, at a minimum, provide all Medicare covered benefits. In addition, there were several requirements added by the Balanced Budget Act of 1997 (BBA) that benefit many enrollees. These requirements are discussed below.

1. Emergency and Post-Stabilization Coverage

The BBA rules strengthened coverage for enrollees who receive care on an emergency basis. Emergency and urgently needed services must be covered regardless of whether they were obtained within the plan or out of plan. The BBA rules make very clear that a plan cannot require prior authorization for emergency services. The standard for assessing whether an emergency existed must be that of a prudent layperson. A plan cannot later deny coverage if a plan provider or other representative had advised the enrollee to seek emergency services.

In the past, there have been many disputes as to when coverage of an emergency ends and as to the standard for assessing when an enrollee is stabilized enough to be transferred to a plan provider or to be discharged. The BBA rules specify that the physician treating the enrollee in an emergency is the one to decide when the enrollee is stabilized enough to be transferred or discharged, and that that physician's decision is binding on the MA plan. Thus, the MA plan must cover the out of plan care until the physician

treating the emergency decides that the emergency or urgent situation is past.

If an enrollee obtains emergency services out of plan, a MA plan may not charge an enrollee more than either $50 or the amount the plan would have charged if the enrollee had obtained the services in the plan, whichever is less.

2. Complex or Serious Medical Conditions

Plans must have procedures to identify and address the needs of enrollees who have complex or serious medical conditions. These procedures must provide for:

- assessing, diagnosing and monitoring such conditions on an ongoing basis;
- establishing and implementing a treatment plan appropriate to the particular condition; and
- allowing such enrollees to have direct access (without prior approval each time) to appropriate specialists for an adequate number of visits based upon the treatment plan.

The MA plan must arrange for specialty care outside of the plan's provider network if the plan's providers are not available or do not have the special expertise to meet the enrollee's medical needs.

3. Women's Health

For women's routine and preventive health care services, women enrollees must be allowed to choose and obtain services directly from a women's health specialist.

4. Written Standards and Policies

Each MA plan must establish written standards and policies for:

- timeliness of access to care and access to member services.
- individualized medical necessity determinations.
- beneficiary's input into the provider's proposed treatment plan.

5. Initial Enrollee Health Assessment

MA plans must make a "best efforts" attempt to assess an enrollee health care needs within 90 days of enrollment. This will help identify and address enrollees' health problems early on.

6. Culturally Competent Services

Medicare rules require that plans ensure that services are provided in a culturally competent manner to all plan enrollees. The rules specifically mention enrollees with limited English proficiency or reading capability and enrollees with diverse cultural and ethnic backgrounds.

This new rule should have practical and positive consequences with regards to marketing by plans, provision of written materials to enrollees, and in the manner in which services are delivered.

7. Changes in Benefits

Except for benefits mandated by the Medicare program, MA plans can change their covered benefits. Changes in covered benefits are allowed, but there are requirements about disclosing such changes so that enrollees have advance notice of them.

If an MA plan wishes to change some of its additional or supplemental benefits or some of its rules, it must first obtain approval from CMS before implementing such changes. In addition, the MA plan must give all of its Medicare enrollees at least 30 days written notice before the changes become effective.

C. Appeals

Beneficiaries who are unhappy with a decision made by their Medicare Advantage plan about their health care can pursue one of four options. They can:

- Argue their case through the MA appeals process;
- Request an expedited appeal if appropriate;
- Request a fast track appeal, if appropriate; or

- File a complaint through the internal grievance procedure.

For information on these options, see Chapter Six, Medicare Claims and Appeals.

Information MA Plans Must Automatically Disclose To Medicare Members

- a comparison to the benefits offered under the original Medicare program;
- any beneficiary liability for balance billing;
- beneficiary grievance and appeals rights under original Medicare and those under the MA plan;
- the fact that the MA plan may not discriminate against a beneficiary because of health or health history;
- a beneficiary's ability to obtain care from out of plan providers;
- the types of providers that are in the plan's network and the extent to which an enrollee may select from those providers;
- the availability of quality of care information including disenrollment rates for the prior two years, enrollee satisfaction, health outcomes, and plan-level appeal statistics;
- coverage of emergency services including the lay-person definition of emergency and the fact that prior authorization can not be required for coverage of emergencies; and
- any prior authorization and other rules that must be met in order to obtain plan coverage of medical care.
- Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.

Chapter 6
Medicare Claims and Appeals

I. Introduction

Beneficiaries who have not joined a Medicare Advantage plan receive their medical care in the traditional fee-for-service system, referred to as "Original Medicare." For purposes of administering claims, Original Medicare is divided into two parts: Part A and Part B. The Medicare program contracts with private insurance companies to process Medicare claims. Different private companies process different types of Medicare claims, as discussed more specifically below.

Beneficiaries who are dissatisfied with a claims determination have the right to appeal the unfavorable determination. Beneficiaries' appeal rights used to differ somewhat under Part A and Part B. Federal legislation passed in 2000 and 2003, however, made significant changes to the Medicare appeals process, many of which take effect in 2005. Most of these changes are designed to make Part A and B appeals more uniform, creating a single appeals system for Parts A and B. The Medicare fee-for-service appeal processes and recent changes are in Section III.

For those beneficiaries who have enrolled in a Medicare Advantage (MA) plan, any out of plan claims or other claims for payment must be submitted to the MA plan. Beneficiaries who are dissatisfied with an MA plan determination or MA refusal or failure to provide services may file an appeal. The appeals process for MA enrollees is presented in Section

V of this chapter. Once a Medicare Advantage appeal leaves the external, independent review stage, the appeal steps are the same as in fee-for-service, discussed in Section III.

In addition, the new Medicare Part D prescription drug benefit has a separate appeals process that originates with the Part D plan (including a Medicare Advantage – Prescription Drug plan or MA-PD). Part D appeals are in Section VI.

II. Medicare Fee-For-Service Claims

The Medicare program contracts with private insurance companies to process claims. The companies that process Part A claims are different than the companies that process Part B claims.

The companies that process Medicare Part A claims are called "fiscal intermediaries" or "intermediaries." Claims for home health services, regardless of whether covered under Part A or Part B, are processed by fiscal intermediaries. In California, the companies that process Medicare Part A claims are United Government Services and Mutual of Omaha. The addresses and telephone numbers for the intermediaries are listed at the end of this chapter.

The companies that process Medicare Part B claims are called "carriers." The carrier for all of California is National Heritage Insurance Company (NHIC). The addresses and telephone numbers for NHIC are listed at the end of this chapter.

Although Durable Medical Equipment (DME) and supplies are covered under Part B, a separate carrier processes claims for these items. The DME carrier that handles claims from California is CIGNA, and is located in Tennessee. The address and telephone number for CIGNA is listed at the end of this chapter.

Both Part A and Part B claims must be submitted by the health care provider to the fiscal intermediary or carrier. The only exception to this requirement is if the beneficiary has other insurance that is primary and

Medicare is the secondary payer. Generally, claims must be submitted by the end of the calendar year following the year of the date of service. However, medical services provided during the last three months of the calendar year are treated as being provided during the next calendar year to allow a longer period of time for submitting claims. Providers may not charge for filing a Medicare claim.

> ***EXAMPLE:***
>
> *Mr. Bates had surgery on September 15, 2005. The hospital has until December 31, 2006 to submit a claim for payment to the Medicare intermediary.*
>
> *However, if the surgery was performed on November 15, 2005, (during the last three months of the calendar year) the hospital would have until December 31, 2007, to submit a claim for payment to the Medicare intermediary.*

Beneficiaries are informed of the initial determination on each claim through a Medicare Summary Notice (MSN) form which is mailed to them. A sample MSN is included at the end of this chapter or it may be found on the Medicare Web site at **www.medicare.gov/basics/summarynotice.asp**.

The most common reasons for beneficiaries to be dissatisfied with the initial determination on a claim are that the claim is denied altogether or that the claim is covered but the Medicare-approved amount is far lower than the charge for the service. An appeal may be filed in either situation.

By the year 2011, a new type of entity will fully replace Medicare carriers and intermediaries. The Medicare Modernization Act (MMA) created a new type of administrative entity called a Medicare Administrative Contractor, which will perform all of the current functions of carriers and intermediaries through one organization. Just as there are several carrier and intermediaries throughout the country, there will likely be

several Medicare Administrative Contractors. They will begin to be phased into the Medicare program in 2005.

III. Medicare Fee For Service Appeals – Parts A & B

A. Overview Of Medicare Appeals

The federal Benefits Improvement and Protection Act of 2000 (BIPA), along with the Medicare Modernization Act of 2003 (MMA), restructured the Medicare appeals process to create a single appeals system for claims under Parts A and B. Most of these changes are being implemented, for the first time, in 2005 and are scheduled to be fully in effect in 2006. Many of these changes are expected to result in faster, more efficient handling of Medicare appeals; other changes, however, are of concern to advocates.

1. Changes to the Medicare Appeals Process:

- Expedited Appeals for termination of certain services, such as hospital, skilled nursing facility, home health, hospice and comprehensive outpatient rehabilitation facilities;
- A new type of CMS-contracting entity called the Qualified Independent Contractor (QIC);
- The dollar amounts that must be at issue before a beneficiary has a right to file for an ALJ hearing and in federal court.

2. Steps of the Appeals Process

Medicare appeals, whether under A, B, C (Medicare Advantage) or D, all have the same steps. The names of the appeal steps and entity that handles each step, however, may be different between fee-for-service, Medicare Advantage and Part D. Each appeals process follows a standard pattern:

- ***Initial decision:*** made by a Medicare contractor (whether it is a carrier, intermediary, Medicare Advantage plan or Part D plan);
- ***First level of appeal***: the same entity that made the initial decision (whether it is a carrier, intermediary, Medicare Advantage plan or Part D plan) reviews their initial decision;
- ***Second level of appeal:*** external review by an outside, independent entity that contracts with CMS; in fee-for-service, it is called the "Qualified Independent Contractor" (QIC) and for Medicare Advantage and Part D it is called an "Independent Review Entity" (IRE);
- ***Third level of appeal:*** an Administrative Law Judge (ALJ) hearing (as long as enough money is at issue);
- ***Fourth level of appeal:*** Medicare Appeals Council (MAC); and
- ***Fifth level of appeal:*** Federal District Court (as long as enough money is at issue).

The Medicare appeals process is complex. These new changes add several layers of complexity that cannot all be addressed in this chapter. There are additional rights to which beneficiaries may be entitled, as well as corresponding rules about what type of evidence can be submitted and when. HICAP counselors should consult their manager and/or legal counsel for further information on Medicare appeals.

B. Initial Determination

Once a claim for Medicare coverage or payment has been processed by the Medicare carrier or intermediary, a Medicare beneficiary will be sent a Medicare Summary Notice (MSN). This notice advises the beneficiary whether or not Medicare will pay for the services and how much the beneficiary must pay. If Medicare will not pay for the services, the MSN should provide the reason why Medicare coverage

is denied. A beneficiary who is dissatisfied with the Medicare determination may file an appeal.

C. Redetermination

The first level of appeal in fee for service is called a redetermination. If a beneficiary wants to appeal an initial determination, she/he must submit a written, signed request for a redetermination within 120 days (approximately four months) of the initial determination. The MSN will direct the beneficiary where and how to file a request for redetermination, which is the first step in the appeals process. Requests for redetermination can no longer be filed at the local SSA office. Providers and suppliers can also submit appeals (which may delay the appeals process if they file after a beneficiary does). The appropriate Medicare contractor (intermediary or carrier) must issue a decision within 60 days.

D. Reconsideration (External Review)

A beneficiary who is dissatisfied with a redetermination decision can file a request for reconsideration. Reconsiderations, the second level in the appeals process, are conducted by a new type of Medicare contractor call a Qualified Independent Contractor (QIC). QICs will conduct an external, independent review of redeterminations. As of May 2005, the QIC contractor is Maximus/CHDR, which is the same entity that handles external reviews for Medicare Advantage appeals.

Beneficiaries have 180 days to request reconsideration after a redetermination is issued. Requests for reconsideration can also be filed by providers/suppliers.

This level of appeal replaces the previous Part B fair hearing, and adds another level of review for Part A claims before an ALJ hearing. The reconsideration process is being phased in during 2005. Since May 1, 2005, Part A appeals to fiscal intermediaries have gone through QIC reconsideration. Appeals of Part B redeterminations, however, will go to fair hearing at the carrier through the rest of 2005. Reconsideration

of Part B redeterminations issued on or after January 2006 will be conducted by QICs.

The QIC must issue its decision of the reconsideration within 60 days. Beneficiaries can request an extension of 14 days. (Also, an additional 14 days are added each time additional evidence is submitted to the QIC).

If a QIC does not issue a timely decision, a beneficiary can request that the appeal be "escalated" to the next level of review – Administrative Law Judge hearing. Once a request for escalation is made, the QIC has five days to either issue a decision or send the request to the ALJ level. An ALJ normally has a 90-day period within which to issue a decision; if an appeal is escalated to the ALJ level, without a QIC decision however, the time period is extended to 180 days.

E. Administrative Law Judge (ALJ) Hearing

If a beneficiary is not satisfied with a QIC decision, she/he may file a request for an Administrative Law Judge (ALJ) hearing. A beneficiary must file for an ALJ hearing within 60 days of receipt of an unfavorable QIC decision. An ALJ has 90 days to issue a decision, but this time frame can be extended for various reasons, such as submission of new evidence, an "escalated" request from the QIC, and if a request for an "in person" hearing.

In order to have a right to an ALJ hearing, there must be a certain amount of money at issue (an "amount in controversy" or AIC). For example, there must be at least $100 at issue in 2005. This amount increases annually.

Until October 2005, ALJ hearings were conducted through Social Security's Offices of Hearings and Appeals, which has approximately 140 offices located in various parts of the country (including about 16 in California). One of the changes to the Medicare appeals process is an MMA requirement that moves ALJ hearings from Social Security to the federal Department of Health and Human Services, (DHHS).

This change in ALJ hearings has several consequences, including less availability for in person hearings. There will only be four offices nationwide (including one in Irvine, California) that will house ALJs. ALJ hearings will be held by:

- Video teleconferencing (VTC);
- Telephone; or
- In-person (at the ALJ's discretion, if a beneficiary can show "good cause" as to why the hearing should be in person).

F. Medicare Appeals Council (MAC)

The Medicare Appeals Council (MAC) is part of the Department Appeals Board of the federal Department of Health and Human Services – the same federal agency that CMS is under. A beneficiary who has received an unfavorable ALJ decision has 60 days to request a MAC review. Most MAC reviews will not be in person; instead, the MAC will review the relevant documents and issue a decision. A MAC has 90 days to issue a decision, but this time period can be delayed for several reasons.

G. Federal District Court

A beneficiary who is still dissatisfied with the MAC decision can file a lawsuit in federal district court. This suit must be filed within 60 days of receipt of an unfavorable MAC decision. In order to have a right to file such a suit, however, there must be a certain amount in controversy, for example, at least $1,050 in 2005. This amount increases annually.

As of May 2005, there is a right to go to federal court in place of an ALJ or MAC review – called an expedited access to judicial review. This is available in certain cases in which the facts are not in dispute, but a beneficiary is challenging CMS law or policy.

H. Expedited Appeals

Termination of Services from Hospitals, Skilled Nursing Facilities, Home Health Agencies, Hospice and Comprehensive Outpatient Rehabilitation Facilities

1. Overview

The federal law that changed the Medicare appeals process also required a process for beneficiaries to obtain an independent, expedited determination if they face a termination of certain services. Until recently, in the fee-for-service setting, the right to expedited review only existed in the context of hospital discharges. First, hospital discharges will be discussed, followed by expedited appeals regarding termination of services by skilled nursing facilities (SNFs), home health agencies (HHAs) and comprehensive outpatient rehabilitation facilities (CORFs).

2. Hospital Discharges; Patient Protections

a. Notice of Non-Coverage

A hospital must tell a Medicare patient in advance that he or she will be discharged from the hospital. Hospitals are not required to give beneficiaries this decision in writing up front through a Notice of Non-Coverage. Instead, beneficiaries who disagree with the hospital's decision must ask the hospital for a "Hospital-Issued Notice of Non-Coverage (HINN)" if in Original Medicare, or a "Notice of Discharge and Medicare Appeal Rights (NODMAR)" if in a Medicare Advantage plan. These notices will explain why they are being discharged and provide additional information on their appeal rights.

Some of the information that is included in these requested Notices of Non-Coverage is provided to the beneficiary in the form of "an Important Message from Medicare", which is given to the patient upon admission or shortly afterward. The information should include, at the very least, the beneficiary rights regarding the hospital discharge and how to appeal the decision if the patient is so inclined. While it is good that

beneficiaries are given some of these important appeal rights information up front, oftentimes that information may go unnoticed unless a beneficiary has an advocate and/or family member with him/her when being admitted into a hospital. Therefore, it is important that beneficiaries are aware of their appeal rights, or at least their right to request a Notice of Non-Coverage if the hospital tells them they will be discharged before they are ready to return home, and/or they will no longer pay for care. If requested, the written notice "Notice of Non-Coverage" usually comes from the hospital's Utilization Review Committee (URC).

Each written Notice of Non-Coverage must include:

- the date and time the notice was received by the patient;
- the reasons why inpatient hospital care is no longer required;
- a description of how to appeal the decision to discharge the patient;
- the date the patient's liability for the cost of the hospital stay begins if the patient stays in the hospital and loses the appeal; and
- a place for the patient to sign that she/he received the notice.

b. Appeal of Hospital Discharge

If a Medicare patient believes that he or she is not medically ready to be discharged from the hospital, he or she should follow the instructions on the Important Message from Medicare and immediately appeal the discharge. A Medicare patient may appeal the discharge even if the hospital has failed to provide the required Hospital-Issued Notice of Non-Coverage (HINN), or the Notice of Discharge and Medicare Appeal Rights (NODMAR) for those in Medicare Advantage

plans. Such appeals are made to Lumetra, the Medicare Quality Improvement Organization (QIO) for California. See the end of this chapter for Lumetra's contact information. The following paragraphs describe Medicare patients' appeal rights regarding hospital discharge.

1. Immediate (Expedited) Appeal

If the patient's physician agreed with the discharge decision, the beneficiary has the right to an immediate, expedited appeal of this decision.

If a Medicare patient does not request an immediate appeal or does not have the right to do so, he or she will be liable for the cost of the hospital stay beginning at noon of the day after the Notice of Non-Coverage is provided.

In order to exercise his/her right to an immediate appeal of the discharge decision, a Medicare beneficiary must contact the QIO no later than noon of the first working day following the patient's receipt of the Notice of Non-Coverage. The patient should ask the QIO to review the hospital's decision. The request may be in writing or may be verbal. To have the best chance of stopping the discharge, the patient should be ready to tell the QIO why he or she is not medically ready to be discharged.

If the QIO issues a favorable decision, Medicare will continue to pay for the care. If an immediate appeal is requested within the above time limit and the QIO decides against the patient, the hospital may charge the beneficiary for the hospital stay beginning at noon on the day following the patient's receipt of the unfavorable QIO decision.

EXAMPLE:

On Monday, March 20, Harold J., a Medicare inpatient at Samaritan West, received a written Notice of Non-Coverage from the hospital that he no longer required hospital care and that Medicare would no longer pay for his hospital stay. The Notice indicated that Mr. J's physician agreed with this decision. The following morning, Tuesday, March 21, Mr. J. appealed to the Medicare QIO. The QIO ruled against Mr. J. on Thursday, March 23. In this case, the hospital may begin charging Mr. J. at noon on Friday, March 24.

2. Reconsideration by QIC

If the QIO has decided against the patient through the immediate appeals process, the Medicare patient has the right to request that another entity, the Quality Independent Contractor (QIC), review the QIO's unfavorable decision. The beneficiary must request reconsideration by the QIC by no later than noon of the calendar day following the receipt of the QIO decision.

When a beneficiary makes a request for reconsideration to the QIC within this timeframe, the hospital may not bill the beneficiary until the QIC makes its decision. A beneficiary who does not file a request for reconsideration within this timeframe must go through the standard appeals process.

3. Medicare Advantage (MA) Enrollees

Medicare Advantage (MA) plan (including Medicare HMO) members who want to immediately appeal a hospital discharge must choose between an appeal to the QIO or using the Medicare Advantage expedited appeals process. If MA enrollees choose to appeal through the MA plan rather than the QIO process, however, MA enrollees will be liable for the cost of the hospital stay beginning at noon

the day after the Notice of Non-Coverage is provided. If an immediate QIO appeal is requested, the same rules apply to Medicare Advantage plan enrollees as to other Medicare patients. Thus, in order to be protected from financial liability for the hospital stay during an appeal, MA enrollees should use the QIO process rather than the MA appeals process.

4. Further Appeal Rights

Following the reconsideration stage, Medicare patients have the same appeal rights with respect to Medicare coverage of hospital stays as they do with respect to other Medicare Part A services. The appeals processes for Medicare Part A, Medicare Part B, Medicare Advantage plans, and Medicare Part D are all discussed in this chapter.

c. Discharge Planning

Hospitals are required to provide discharge planning for their Medicare patients, including a written discharge plan (if a patient requests one). Discharge planning is a process that helps ease the transition of patients from the hospital to the home, nursing home or other care facility. Discharge planning services are generally provided through hospital social workers. A discharge plan should include an assessment of the patient's need for home care, skilled nursing or rehabilitation facility care, physical, speech and/or occupational therapy and durable medical equipment. It should also include a plan as to how such care and equipment will be provided to the patient.

3. Skilled Nursing Facilities, Home Health Agencies, Hospice and Comprehensive Outpatient Rehabilitation Facilities

Beginning July 1, 2005, a beneficiary also has the right to an expedited determination and reconsideration when services are terminated by a skilled nursing facility (SNF), home health agency

(HHA), hospice, or comprehensive outpatient rehabilitation facility (CORF).

a. Steps in an Expedited Appeals Process

1) Provider gives beneficiary notice of termination/discharge;

2) Beneficiary appeals decision to the Quality Improvement Organization (QIO), called Lumetra in California;

3) QIO issues a decision;

4) Beneficiary has right to request reconsideration by Qualified Independent Contractor (QIC) – Maximus/ CHDR.

If a SNF, HHA, hospice or CORF provider plans to terminate services, the provider must give notice to the beneficiary no later than two visits or two days before the proposed end of services. The beneficiary may appeal if:

- She/he disagrees with the termination of service; and
- If services are from an HHA or CORF, a physician certifies that failure to continue the service may place the beneficiary's health at significant risk.

b. Expedited Determination

If a beneficiary wishes to appeal the termination decision on an expedited basis, she/he must request an expedited appeal by noon of the day prior to termination of services. This can be done by phone or in writing to Lumetra. The provider then must send a detailed notice to the beneficiary explaining why the services are either no longer reasonable and necessary or are no longer covered. The provider must continue services until two days after the provider gave the beneficiary the first notice, or until the service termination date, whichever is later.

Lumetra must issue a decision within 72 hours of receipt of a request for an expedited appeal. The initial notice of the

Lumetra decision must be by telephone and written notice must follow. This written decision must include:

- A detailed explanation of the decision;
- A statement explaining when the beneficiary is liable for payment for the services; and
- Information about a beneficiary's appeal rights, including how to request a reconsideration.

c. Expedited Reconsideration

A beneficiary who is not satisfied with the Lumetra's expedited determination may request an expedited reconsideration by the QIC (Qualified Independent Contractor) called Maximus/CHDR nationwide. The request must be in writing or by telephone, submitted no later than noon of the calendar day following the initial notification from the Lumetra about the their decision, whether by telephone or in writing.

The QIC must issue a decision within 72 hours after a request for expedited reconsideration is received. This period may be extended up to 14 days by the beneficiary and also if more time is needed to collect medical records. The QIC decision may be by phone, followed by a written notice that includes the same information required above in the Lumetra decision. A beneficiary's next level of appeal, should she/he wish to pursue it further, is an Administrative Law Judge (ALJ) hearing.

IV. Medicare Advantage Claims

For the most part, enrollees in Medicare Advantage (MA) plans should not have claims that must be submitted for payment. Physicians and medical providers who contract with the MA plan should not bill or collect any fees from the enrollee other than the usual MA plan co-payments.

An MA enrollee may receive emergency or urgently needed care outside of the plan. Another possible scenario is that the MA enrollee needed out of plan care that the MA plan refused or failed to provide.

Any claims for payment for medical services should be submitted to the MA plan. If an MA enrollee submits or has claims submitted to Medicare (i.e. the fiscal intermediary or carrier that processes fee-for-service claims), such claims will be denied on the basis that the beneficiary is enrolled in an MA plan. If the MA plan approves the claim for payment, it will pay the out of plan provider. If the MA plan denies the claim for payment, then the beneficiary may appeal that denial by following the MA appeals process described below.

V. Medicare Advantage Appeals

A. Overview

Medicare Advantage plans must provide a specified appeals procedure for enrollees who are dissatisfied with certain decisions by the plan or its providers. These appeals procedures apply to matters that are considered an "organization determination."

The appeals procedure for Medicare Advantage determinations is similar to the fee-for-service structure, although the names of the steps and entities involved are sometimes different. After the external review, the last three steps in the appeals process are the same as fee-for-service.

1. Steps in MA the Appeals Process:

- Organization Determination: made by MA plan;
- First appeal step: Reconsideration by MA plan;
- Second appeal step: External review by Independent Review Entity (IRE) – Maximus/CHDR;
- Third appeal step: Administrative Law Judge (ALJ) hearing;
- Fourth appeal step: Medicare Appeals Council (MAC);

- Fifth appeal step: Federal District Court

A discussion of each of these steps is outlined below. Organization determinations are subject to an expedited appeal process when the following services are being terminated: hospital, skilled nursing facility (SNF), home health agency (HHA) and comprehensive outpatient rehabilitation facilities (CORF). Expedited appeals in these settings, as well as the MA grievance process, are discussed separately.

B. Organization Determinations

An organization determination is generally the first decision an MA plan makes concerning services provided to an enrollee. The scope of what is considered to be an organization determination by a Medicare Advantage plan includes decisions about:

- payment for temporarily out of the area renal dialysis services, emergency services, post stabilization care, or out of the area urgently needed services;
- payment for any other health services furnished by a non-plan provider that the enrollee believes the MA plan should have furnished, arranged or covered, including optional supplemental benefits that are part of the MA plan;
- the MA plan's refusal to provide or pay for services, including;
  - ◊ a denial as to a service altogether or as to the amount of a service, such as the number of home health visits or number of days of skilled nursing facility care;
  - ◊ a denial as to the level or type of service, such as approval of outpatient care rather than inpatient care or approval of skilled nursing facility care rather than hospital inpatient care.
- discontinuation or reduction of services if the enrollee believes the services are still medically necessary;

- failure of the MA plan to approve, furnish, arrange or pay for health care services in a timely manner; and
- failure of the MA plan to provide the enrollee with timely notice of an adverse determination if that delay would adversely affect the health of the enrollee.

Different time frames apply to requests for services and requests for payment. If a beneficiary is requesting a service that has yet to be performed, the MA organization must notify a beneficiary of its determination "as expeditiously as the enrollee's health condition requires," but in no case longer than 14 calendar days after such a request has been made. This time period can be extended for up to another 14 days at the request of the enrollee or by the plan, if the plan can show that such a delay is in the beneficiary's interest. If the plan extends the period, it must give the enrollee a written notice of the reasons for the delay and his or her right to file a grievance challenging the extension. MA plans must process most requests for payment within 30 days and all claims within 60 days after receipt.

If the determination is to deny a medical service or to deny payment for a medical service (or claim), the plan must give written notice of this denial. The written notice must include:

- the reason for the denial in understandable language;
- instructions on how to appeal the denial; and
- instructions on how to obtain an expedited appeal.

If a written notice is not given, as required, the enrollee may treat the situation as a denial and request reconsideration of the denial, which is the next step in the appeals process.

1. Expedited Organization Determinations

If a medical service or discontinuation of a medical service is at issue, the enrollee or any doctor (whether or not affiliated with the MA plan) may request an expedited determination. A request for expedited determination may be made either in writing or orally.

If it is made orally, beneficiaries and their advocates should make sure to keep a record of the name, title and telephone number (including extension) of the plan employee who took down the request. The right to an expedited determination does not apply if the enrollee has already received the service out of plan and is simply submitting a claim for payment. If the MA organization has already refused to provide or denied a medical service, or has advised that a medical service will be discontinued, this may be treated as an organization determination and the beneficiary may simply request reconsideration.

If any physician requests that the MA plan's determination be expedited, the plan must expedite its determination. If an enrollee is the one requesting that a determination be expedited, the plan is not required to grant the request. Instead, the MA plan, which has already failed to provide the service, decides whether or not to expedite, based upon the plan's assessment of whether the 14-day standard time frame for organization determinations "could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function."

If an organization determination is expedited, the MA plan must make its decision "as expeditiously as the enrollee's health condition requires," but in no event later than 72 hours after receiving the request for an expedited determination. This 72-hour time frame can be extended up to 14 calendar days if either the enrollee requests the extension or if the plan shows that it needs to obtain additional information and that doing so is in the best interest of the enrollee. However, if the plan believes it needs an extension, it must give the enrollee written notice of this fact including the reason that it requires additional time to process the appeal.

A plan must notify the enrollee (and the physician, if a physician requested the expedited determination) of its decision in writing, including the specific reasons for the determination, in language

that is easily understandable. If the determination is not favorable to the enrollee, the notice must also advise the enrollee of his/her right to request a standard or expedited reconsideration.

If an enrollee requests an expedited determination and the MA plan denies that request, CMS requires the plan to give the enrollee prompt oral notice of the denial and also deliver to the enrollee, within three calendar days, a written letter that includes the following:

- an explanation that the request will be automatically processed using the 14-day standard time frame;
- the enrollee's right to resubmit the request for an expedited determination with any physician support; and
- the enrollee's right to file a grievance regarding the fact that the request is not being expedited.

C. Reconsideration By A Medicare Advantage Plan

1. Standard Reconsideration

Medicare Advantage plan enrollees who are dissatisfied with a plan's organization determination may request that the plan reconsider its decision. An enrollee can ask for a reconsideration by making a written request to the MA plan. A request for reconsideration must be filed within 60 calendar days from the date of the notice of the organization determination. This time frame can be extended for good cause. If a service that a beneficiary has not received is at issue, the MA plan must issue a decision within 30 days. If the issue involves payment for a claim, the MA plan has 60 days to issue a decision. These time frames can be extended by up to 14 days at the request of the beneficiary, or by the plan if it is able to demonstrate that such a delay would be in the best interest of the beneficiary. If the MA plan issues an unfavorable redetermination, the MA plan must automatically forward the appeal to the Independent Review Entity (IRE).

2. Expedited Reconsideration

An enrollee or a physician may request an expedited reconsideration of the MA plan's determination. The time frames mirror those for an expedited organization determination, outlined above. Expedited reconsideration must be completed within 72 hours, but this time line can be extended up to 14 days.

If an MA plan makes an expedited determination favorable to the enrollee, it must orally notify the enrollee as expeditiously as the enrollee's health condition requires but no later than 72 hours after receiving the request. The oral notice must be followed up with a written notice of its decision within three calendar days of the oral notice. If an MA plan makes a reconsideration determination that is not favorable to the enrollee, it must forward the case to the Independent Review Entity within 24 hours of making its determination.

D. External Review By Independent Review Entity

If a Medicare Advantage plan's reconsideration decision is not in favor of the beneficiary, the MA plan must automatically forward the appeal to an outside CMS contractor – the Independent Review Entity (IRE) which is Maximus/Center for Health Dispute Resolution (or CHDR). The MA plan must notify the enrollee that the appeal has been forwarded to the IRE. The IRE must conduct the review as "expeditiously as the beneficiary's health condition requires" but does not have set time frames outlined in CMS rules. Instead, time frames are outlined in a contract between CMS and the IRE. Maximus/CHDR's current time frames for conducting their external review are as follows:

- Expedited reviews: 72 hours to 17 days
- Service denials: 30 to 44 days
- Payment denials: 30 to 60 days

E. Further Stages Of Appeal: ALJ, MAC And Federal District Court

The remaining three stages of the appeals process are the same under Medicare Advantage as they are under the fee-for-service appeals process, outlined in section III. The enrollee has 60 days from the date of the IRE decision to file a request for an Administrative Law Judge (ALJ) hearing and a certain dollar amount must be at issue (for example, $100 in 2005) in order to proceed to that stage. This amount will increase annually. Following the ALJ stage is review by the Medicare Appeals Council and then, finally, a suit may be filed in Federal District Court if a certain dollar amount is still at issue (for example, at least $1,050 in 2005). This amount will also increase annually.

F. Fast-track Appeals

For Skilled Nursing, Home Health and Comprehensive Outpatient Rehabilitation Facility Services

Effective January 2004, MA enrollees have a right to a fast-track appeals process before any termination of skilled nursing facility (SNF) care, home health agency (HHA) care, or comprehensive outpatient rehabilitation facility (CORF) care. A standardized advance termination notice must be given to the beneficiary no later than two days before the end of the service. This notice, called a Notice of Medicare Non-Coverage must explain:

- The date the coverage ends;
- The date when the beneficiary will be responsible for paying for services; and
- The right to appeal.

The provider must carry out a "valid delivery" of the notice, meaning the beneficiary or authorized representative must sign and date the notice to acknowledge receipt (or, alternatively, the authorized representative can be informed over the phone).

If the enrollee disagrees with the termination of services, she/he has a right to an expedited appeal to the Quality Improvement Organization (QIO), Lumetra. The enrollee must contact the Lumetra no later than noon of the day before services are to end. Beneficiaries who request an appeal will be given a detailed termination notice explaining why the services no longer will be provided.

The review process will generally be completed within 48 hours of the beneficiary's request for review – Lumetra must make a decision no later than the day Medicare coverage is expected to end. This right to request a Lumetra review is similar to the right of a Medicare beneficiary to request a review of a discharge from an inpatient or acute care hospital.

G. Grievances

Medicare Advantage plans must provide a grievance procedure in addition to the Medicare Advantage appeals process. As discussed above, the appeals process applies to issues that are considered "organization determinations." Most issues that arise for MA enrollees pertain to a plan's provision of coverage of services, or payment of out of plan claims, and thus fall into the appeals process.

Issues that are not within the definition of an "organization determination" come under an MA plan's grievance process. The grievance process is separate and apart from the appeals process. Sometimes it is difficult to figure out whether an issue should go through the appeals process or grievance process. Examples of issues that are grievances are complaints about waiting times for appointments, rude or discourteous service by plan personnel, or quality of medical care provided.

Grievances can be filed with the MA plan either orally or in writing, and must be filed no later than 60 days after the event or incident giving rise to the grievance. The MA plan must notify the enrollee of its decision no later than 30 days of receipt of the grievance (but this time frame can be extended at the request of the enrollee or if the plan can show that a delay would benefit the enrollee). Grievances

related to the quality of care an enrollee receives in the plan must be responded to in writing, and must include a description of the enrollee's right to file a written complaint with Lumetra.

VI. Part D Appeals

A. Overview

For an overview of the Part D prescription drug benefit, see Chapter Twelve. This section discusses the appeals process only.

The appeals process for Part D prescription drug coverage issues is modeled on the Medicare Advantage appeals process. Similar to fee-for-service and Medicare Advantage appeals, the Part D appeals process includes five steps following a plan's initial coverage determination. Coverage determinations and the first two stages of appeal (redetermination and reconsideration) all have standard and expedited time frames.

1. Steps in the Part D Appeals Process

Coverage Determination: Initial determination made by the plan (including those in response to an exception request);

- ***First level of appeal:*** Redetermination by Part D plan;
- ***Second level of appeal:*** Reconsideration by Independent Review Entity (IRE) – Maximus/CHDR;
- ***Third level of appeal :*** Administrative Law Judge (ALJ) hearing;
- ***Fourth level of appeal:*** Medicare Appeals Council (MAC);
- ***Fifth level of appeal:*** Federal District Court.

Under Medicare Part D, a person may be unable to get the drugs they need for several reasons. Some of these reasons include:

- the requested drug is determined not to be medically necessary;

- the drug is not on the Part D plan's formulary;
- a physician did not receive prior approval from the Part D plan for the prescribed medication;
- the specific drug dosage, method of administration (liquid verses pill) or type (generic versus brand name) is not on the plan's formulary;
- the tiered cost-sharing amount for the drug is too high;
- the Part D plan removes a previously covered drug from the formulary; and
- the pharmacy filling the prescription is not within the Part D plan's network.

All of these scenarios would be "coverage determinations" by a plan and would be subject to an appeal. In two scenarios, described below, a beneficiary must make an "exception request" whereby an enrollee asks his/her plan to grant them an exception to plan rules regarding drugs it covers on its formulary and the cost-sharing it charges for those drugs.

B. Exceptions Requests

Two scenarios are generally subject to an exceptions request: when a beneficiary is requesting a drug that is not on a plan's formulary; and when a beneficiary is requesting an exception to a plan's tiered cost-sharing structure. In other words, the enrollee is asking that a drug subject to higher cost-sharing instead be subject to lower cost-sharing.

In general, Part D plans must grant exceptions requests by enrollees when such a request is "medically necessary." Specifically, a plan must grant requests in the following situations:

- ***Exception request for non-formulary drug:*** When a prescribing doctor determines that all the drugs on the formulary would not

be as effective as the non-formulary drug or would have adverse effects;

- ***Exception request for tiered cost-sharing:*** When a prescribing doctor determines that the preferred drug for the treatment of the condition would not be as effective as the non-preferred drug or would have an adverse effect.

The exception process can also be used when the plan changes its formulary and cost-sharing structure during the course of a calendar year, when the enrollee is using a drug that has been removed from the formulary, and when the cost-sharing status of a drug an enrollee is using changes.

Unlike other issues subject to a coverage determination, these exception requests require both beneficiaries and their prescribing physicians to take action. Part D plans have a certain amount of discretion in how they structure their exceptions and appeals processes. For example, a plan may require a prescribing physician to provide written support and additional medical documentation in order to support a beneficiary's exception request. Plans must provide information to beneficiaries and their physicians about that plan's procedures for processing such requests, including how medical evidence will be reviewed.

Formulary exceptions, if granted, last the remainder of the calendar year (as long as a physician continues to prescribe the drug in question). Beneficiaries who renew their enrollment in the same Part D plan at the end of the year may be required to submit a new exception request in the new plan year.

C. Coverage Determinations

1. Starting the Process

In most cases, a beneficiary will have to take active steps in order to start the plan's appeal process. Transactions that occur at the pharmacy will not start this process; for example, when a

beneficiary is told "your drug is not covered by your plan." If a beneficiary disputes coverage or cost information that they are being given by the pharmacy, drug plan participating pharmacies will be required to either post or give standard notices to enrollees directing them to their plan or 1-800-MEDICARE. The burden is on the beneficiary to contact the Part D plan, find out why they won't cover the drug, and learn about appeal rights and options. It is possible that many people will "fall through the cracks" at this stage. If beneficiaries do not take action, they may not get the drugs they need.

2. Once the Plan Has Been Contacted

The plan decision-making process will not begin until the beneficiary contacts the plan. There is both a standard coverage determination time frame, and an expedited time frame in certain instances.

a. Standard Coverage Determination

A beneficiary must submit a request for a coverage determination to their plan. Once an exception request has been made to the plan, the plan must issue a coverage determination.

After requesting a coverage determination, the Part D plan must inform the beneficiary (and the prescribing physician if the physician requested the coverage determination), of the plan's decision no later than 72 hours after receiving the request. If the plan denies coverage of the prescribed medication, the plan must give the beneficiary a written notice within 72 hours explaining the reason for the denial and how to continue in the appeals process. If no written notice is given to the beneficiary within the specified time frame, the plan must send the coverage determination request to the Independent Review Entity (IRE) within 24 hours.

b. Expedited Coverage Determination:

A beneficiary or his/her doctor can request an expedited coverage determination if the standard time frame may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. If the doctor makes or supports this request, the plan must use the expedited time frame. If, however, the doctor does not request or support the request for an expedited decision, the Part D plan can decide whether or not to use this shorter time frame.

An expedited coverage determination must be made within 24 hours of when the plan receives the request. Although the plan may first notify the person of their decision within the 24-hour time frame by telephone, the plan must mail the beneficiary a written expedited coverage determination within three calendar days of any oral notification. The notice is required to explain the plan's reasons for reaching its decision and, if the decision is not favorable, must explain how to further proceed in the appeals process.

If the plan does not give the beneficiary a written notice about its expedited coverage determination within the time frames specified, the plan must send the beneficiary's request for an expedited coverage determination to the Independent Review Entity (IRE).

D. Redetermination By Plan

If the plan makes an unfavorable coverage determination, the enrollee or his/her appointed representative may appeal the decision to the plan within 60 days from the date of the notice of the coverage determination. This time period can be extended if the beneficiary can show good cause why she/he filed late. A Part D plan has seven days from the time they receive a request to issue a standard redetermination decision.

Similar to the rules outlining coverage determinations explained above, a beneficiary or his/her physician can request an expedited redetermination. A Part D plan must issue an expedited redetermination decision within 72 hours. Expedited redeterminations are not available if a beneficiary is requesting payment for a drug that has already been furnished or is appealing the cost-sharing amount of a drug.

If a Part D plan does not give the beneficiary a written notice about its expedited redetermination within the time frames specified, the plan must send the beneficiary's request for either a standard or expedited redetermination to the Independent Review Entity (IRE).

E. Reconsideration By Independent Review Entity

Following a Part D plan's redetermination, the next step in the appeals process is reconsideration by an Independent Review Entity (IRE) – the same entity that conducts external reviews in the Medicare Advantage appeals process, which is Maximus/CHDR. Unlike the Medicare Advantage appeals process, however, unfavorable redeterminations by a plan are not automatically forwarded to Maximus/CHDR. Instead, a beneficiary who wishes to continue a Part D appeal at this stage must file a request for reconsideration with the Part D plan.

This request must be made within 60 days of receiving a redetermination denial notice. Maximus/CHDR is required to ask beneficiaries' prescribing physicians for their opinions on the appeal. They must include a written account of the physician's input in the reconsideration documentation.

If requesting a reconsideration of a formulary exception, a beneficiary's prescribing physician must again state that no other drug on the plan's formulary would be as effective for treatment, and/or that all other formulary drugs used to treat the given condition would cause harmful side effects. Maximus/CHDR must send a notice of reconsideration after reaching its decision.

Maximus/CHDR must conduct the review as "expeditiously as the enrollee's health condition requires" but does not have set time frames outlined in CMS rules. Instead, time frames are outlined in a contract between CMS and Maximus/CHDR.

F. Further Stages Of Appeal – ALJ, MAC and Federal District Court

A Part D plan enrollee who is dissatisfied with an IRE reconsideration determination has a right to request an Administrative Law Judge (ALJ) hearing as long as there is a certain amount of money at issue (for example, $100 in 2005). This amount will increase annually. A request for an ALJ hearing must be made within 60 days of receiving the notice of reconsideration from the Maximus/CHDR. There are several ways to meet the required dollar amount:

- the projected value of the drug or drugs in question over the course of a calendar year can be used;
- two or more appeals by one enrollee can be combined, and, in some instances,
- two or more appeals by several enrollees of the same plan can be combined if they all involve the same drug.

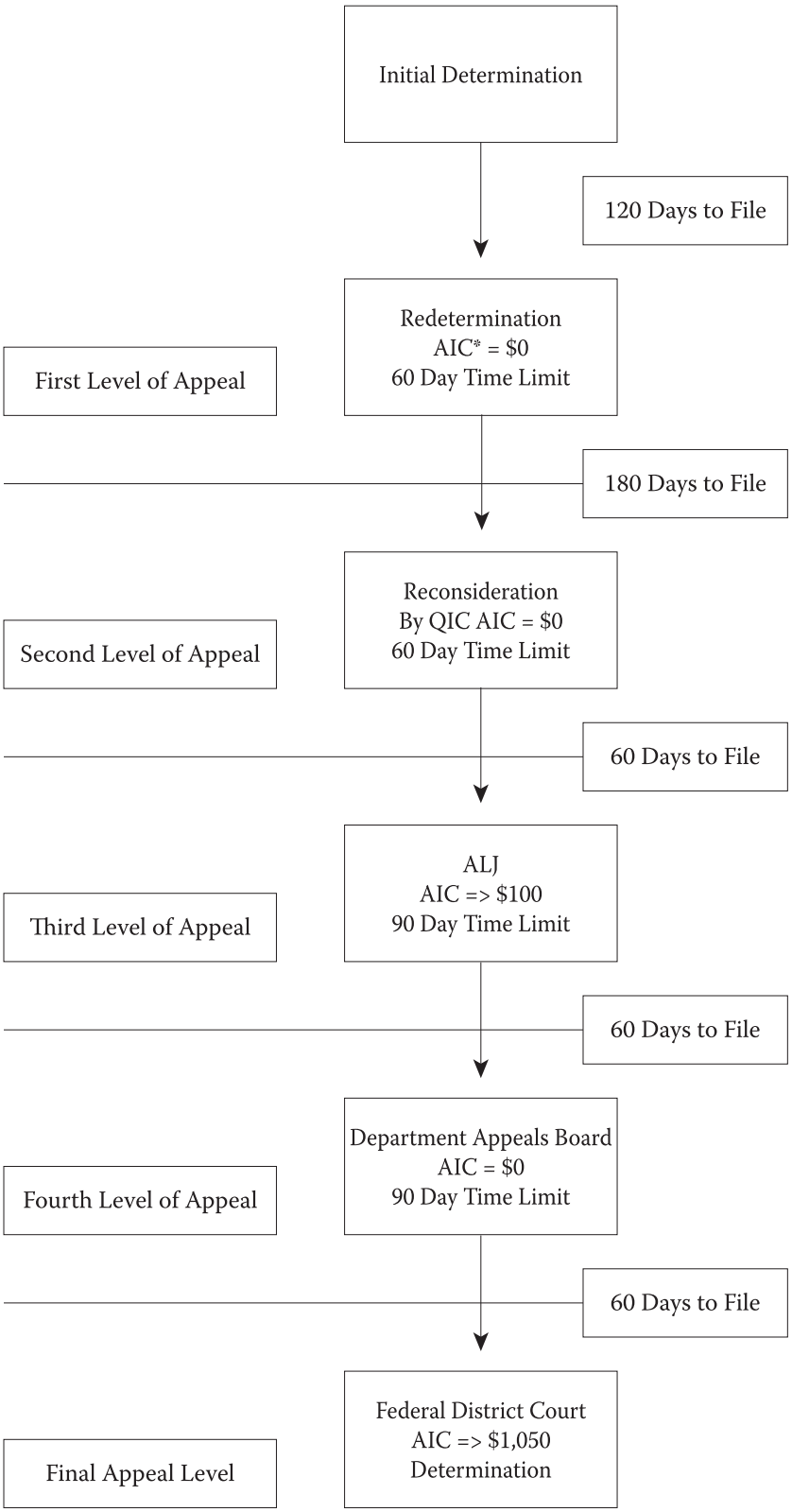
If the ALJ decision is unfavorable, a beneficiary can ask the Medicare Appeals Court (MAC) to review the ALJ's decision. Finally, if the MAC review is unfavorable and the appeal meets the required dollar amount (for example, $1,050 in 2005), a beneficiary can file a lawsuit in Federal District Court.

G. Grievances

Part D plans must have a grievance process for complaints or disputes other than ones that involve a coverage determination. This includes dissatisfaction with any aspect of a Part D plan's operations, activities or behavior. Upon receiving a complaint, a Part D plan must promptly determine and inform the enrollee whether the complaint is subject to its grievance or appeal procedures.

Grievances can be filed with the Part D plan either orally or in writing, and must be filed no later than 60 days after the event or incident giving rise to the grievance. The Part D plan must notify the enrollee of its decision no later than 30 days of receipt of the grievance (but this time frame can be extended at the request of the enrollee or if the plan can show that a delay would benefit the enrollee). Grievances related to the quality of care an enrollee receives in the plan must be responded to in writing, and must include a description of the enrollee's right to file a written complaint with Lumetra, the Quality Improvement Organization in California. (See contact information at the end of this chapter).

Medicare Fee-For-Service Appeals Process



*AIC = Amount In Controversy

MEDICARE ADVANTAGE APPEAL TIMEFRAME

	Service Denial Decision	Payment Denial Decision	Expedited Decision
Initial Request (Organization Determination)	within 14 days	within 60 days	within 72 hours
Reconsideration	within 30 days	within 60 days	within 72 hours
External Review by IRE (Independent Review Entity) (MAXIMUS/ CHDR)	within 30 to 44 days	within 30 to 60 days	within 72 hours to 17 days

Note: This does not apply to hospital discharges or termination of services by skilled nursing facilities (SNF), home health agencies (HHA) and comprehensive outpatient rehabilitation facilities (CORFs).

Sample Medicare Summary Notice – Part A

Medicare Summary Notice

July 1, 2004

BENEFICIARY NAME
STREET ADDRESS
CITY, STATE ZIP CODE

BE INFORMED: Beware of "free" medical services or products. If it sounds too good to be true, it probably is.

CUSTOMER SERVICE INFORMATION

Your Medicare Number: 111-11-1111A

If you have questions, write or call:
Medicare
555 Medicare Blvd., Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

Local: (XXX) XXX-XXXX
Toll-free: 1-800-XXX-XXXX
TTY for Hearing Impaired: 1-800-XXX-XXXX

This is a summary of claims processed from 05/15/2004 through 06/10/2004.

PART A HOSPITAL INSURANCE – INPATIENT CLAIMS

Dates of Service	Benefit Days Used	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Claim Number: 12435-84956-84556-45621					a
Cure Hospital, 213 Sick Lane, Dallas, TX 75555					
Referred by: Paul Jones, M.D.					
04/25/04 – 05/09/04	14 days	$0.00	$876.00	$776.00	b, c
Claim Number: 12435-84956-845556-45622					
Continued Care Hospital, 124 Sick Lane, Dallas, TX 75555					
Referred by: Paul Jones, M.D.					
05/09/04 – 06/20/04	11 days	$0.00	$0.00	$0.00	

PART B MEDICAL INSURANCE – OUTPATIENT FACILITY CLAIMS

Dates of Service	Services Provided	Amount Charged	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Claim Number: 12435-8956-8458						d
Medicare Hospital, 123 Medicare Lane, Dallas, TX 75209						
Referred by: Paul Jones, M.D.						
04/02/04	L.V. Therapy (Q0081)	$33.00	$0.00	$6.60	$6.60	
	Lab (3810)	1,140.50	0.00	228.10	228.10	
	Operating Room (31628)	786.50	0.00	157.30	157.30	
	Observation Room (99201)	293.00	0.00	58.60	58.60	
	Claim Total	**$2,253.00**	**$0.00**	**$450.60**	**$450.60**	

(continued)

Your Medicare Number: 111-11-1111A

Notes Section:

a The amount Medicare paid the provider for this claim is $XXXX.XX.

b $776.00 was applied to your inpatient deductible.

c $30.00 was applied to your blood deductible.

d The amount Medicare paid the provider for this claim is $XXXX.XX.

Deductible Information:

You have met the Part A deductible for this benefit period.

You have met the Part B deductible for 2004.

You have met the blood deductible for 2004.

General Information:

You have the right to make a request in writing for an itemized statement which details each Medicare item or service which you have received from your physician, hospital, or any other health supplier or health professional. Please contact them directly, in writing, if you would like an itemized statement.

Compare the services you receive with those that appear on your Medicare Summary Notice. If you have questions, call your doctor or provider. If you feel further investigation is needed due to possible fraud and abuse, call the phone number in the Customer Service Information Box.

Appeals Information – Part A (Inpatient) and Part B (Outpatient)

If you disagree with any claims decision on either Part A or Part B of this notice, you can request an appeal by **November 1, 2004**. Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1. (You may also send any additional information you may have about your appeal.)

3) Sign here _____ Phone number _____

IMPORTANT INFORMATION YOU SHOULD KNOW ABOUT YOUR MEDICARE BENEFITS

For more information about services covered by Medicare, please see your Medicare Handbook.

PART A HOSPITAL INSURANCE (INPATIENT) helps pay for inpatient hospital care, inpatient care in a skilled nursing facility following a hospital stay, home health care and hospice care. Inpatient services are measured in benefit periods. A benefit period begins the first time you receive Medicare covered inpatient hospital care and ends when you have been out of the hospital or skilled nursing facility for 60 consecutive days. There is no limit to the number of benefit periods you may have.

THE AMOUNT YOU MAY BE BILLED for **Part A** services includes:

- **an inpatient hospital deductible** once during each benefit period,
- **a coinsurance amount for the 61st through the 90th days** of a hospital stay during each benefit period,
- **a coinsurance amount for each Lifetime Reserve Day**, which can be used if you have to stay in the hospital more than 90 days in one benefit period. Lifetime Reserve Days may be used only once,
- **a blood deductible** for the first three pints of unreplaced blood furnished to you in a calendar year in some states,
- **an inpatient coinsurance for the 21st through the 100th days** of a Medicare covered stay in a **skilled nursing facility**,
- charges for services or supplies that are **not covered** by Medicare. You may not have to pay for certain denied services. If so, a NOTE on the front will tell you.

PART B MEDICAL INSURANCE (OUTPATIENT FACILITIES) helps pay for care provided by certified medical facilities, such as hospital outpatient departments, renal dialysis facilities, and community health centers.

THE AMOUNT YOU MAY BE BILLED for **Part B** services includes:

- **an annual deductible,** the first **$100** of Medicare Part B charges each year,
- after the deductible has been met for the year, depending on services received, a **coinsurance amount** (20% of the amount charged), or a fixed **copayment** for each service,
- charges for services or supplies that are **not covered** by Medicare. You may not have to pay for certain denied services. If so, a NOTE on the front will tell you.

If you have supplemental insurance, it may help to pay the amounts you may be billed. If you use this notice to claim supplemental benefits from another insurance company, make a copy for your records.

WHEN OTHER INSURANCE PAYS FIRST: All Medicare payments are made on the condition that you will pay Medicare back if benefits could be paid by insurance that is primary to Medicare. Types of insurance that should pay before Medicare include employer group health plans, no-fault insurance, automobile medical insurance, liability insurance and workers' compensation. Notify us right away if you have filed or could file a claim with insurance that is primary to Medicare.

YOUR RIGHT TO APPEAL: If you disagree with any decision on this notice, you have a right to appeal. For **PART A** and **PART B** decisions, you must file an appeal within **120 days of the date of this notice**. Follow the appeal instructions for Part A or Part B on the front of the last page of the notice. If you want **help with your appeal**, you can have a friend or someone else help you. There are also groups, such as legal aid services, that will provide free advisory services if you qualify. To contact us for the names and telephone numbers of groups in your area, please see our Customer Service Information box on the front of this Summary Notice.

HELP STOP MEDICARE FRAUD: Fraud is a false representation by a person or business to get Medicare payments. Some examples of fraud include:

- offers of goods or money in exchange for your Medicare Number,
- telephone or door-to-door offers for free medical services or items, and
- claims for Medicare services/items you did not receive.

If you think a person or business is involved in fraud, you should call Medicare at the Customer Service telephone number on the front of this notice.

INSURANCE COUNSELING AND ASSISTANCE: Insurance Counseling and Assistance programs are located in every State. These programs have volunteer counselors who can give you free assistance with Medicare questions, including enrollment, entitlement, Medigap, and premium issues. If you would like to know how to get in touch with your local Insurance Counseling and Assistance Program Counselor, please call us at the number shown in the Customer Service Information box on the front of this notice.

Medicare Summary Notice

July 1, 2004

BENEFICIARY NAME
STREET ADDRESS
CITY, STATE ZIP CODE

BE INFORMED: Beware of telemarketers offering free or discounted medicare items or services.

CUSTOMER SERVICE INFORMATION

Your Medicare Number: 111-11-1111A

If you have questions, write or call:
Medicare
555 Medicare Blvd., Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

Local: (XXX) XXX-XXXX
Toll-free: 1-800-XXX-XXXX
TTY for Hearing Impaired: 1-800-XXX-XXXX

This is a summary of claims processed from 05/10/2004 through 06/10/2004.

PART B MEDICAL INSURANCE – ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim Number: 12435-84956-84556						
Paul Jones, M.D., 123 West Street, Jacksonville, FL 33231-0024						a
Referred by: Scott Wilson, M.D.						
04/19/04	1 Influenza immunization (90724)	$5.00	$3.88	$3.88	$0.00	b
04/19/04	1 Admin. flu vac (G0008)	5.00	3.43	3.43	0.00	b
	Claim Total	**$10.00**	**$7.31**	**$7.31**	**$0.00**	
Claim Number: 12435-84956-84557						
ABC Ambulance, P.O. Box 2149, Jacksonville, FL 33231						a
04/25/04	1 Ambulance, base rate (A0020)	$289.00	$249.78	$199.82	$49.96	
04/25/04	1 Ambulance, per mile (A0021)	21.00	16.96	13.57	3.39	
	Claim Total	**$310.00**	**$266.74**	**$213.39**	**$53.35**	

PART B MEDICAL INSURANCE – UNASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid You	You May Be Billed	See Notes Section
Claim Number: 12435-84956-84558						
William Newman, M.D., 362 North Street Jacksonville, FL 33231-0024						a
03/10/04	1 Office/Outpatient Visit, ES (99213)	$47.00	$33.93	$27.15	$39.02	c

THIS IS NOT A BILL – Keep this notice for your records.

Your Medicare Number: 111-11-1111A

Notes Section:

a This information is being sent to your private insurer. They will review it to see if additional benefits can be paid. Send any questions regarding your supplemental benefits to them.

b This service is paid at 100% of the Medicare approved amount.

c Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than $39.02. If you have already paid more than this amount, you are entitled to a refund from the provider.

Deductible Information:

You have met the Part B deductible for 2004.

General Information:

You have the right to make a request in writing for an itemized statement which details each Medicare item or service which you have received from your physician, hospital, or any other health supplier or health professional. Please contact them directly, in writing, if you would like an itemized statement.

Compare the services you receive with those that appear on your Medicare Summary Notice. If you have questions, call your doctor or provider. If you feel further investigation is needed due to possible fraud and abuse, call the phone number in the Customer Service Information Box.

Appeals Information – Part B

If you disagree with any claims decision on this notice, you can request an appeal by **November 1, 2004**. Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1. (You may also send any additional information you may have about your appeal.)

3) Sign here _____ Phone number _____

IMPORTANT INFORMATION ABOUT YOUR MEDICARE PART B MEDICAL INSURANCE BENEFITS

For more information about services covered by Medicare, please see your Medicare Handbook.

MEDICARE PART B MEDICAL INSURANCE: Medicare Part B helps pay for doctors' services, diagnostic tests, ambulance services, durable medical equipment, and other health care services. Medicare Part A Hospital Insurance helps pay for inpatient hospital care, inpatient care in a skilled nursing facility following a hospital stay, home health care and hospice care. You will be sent a separate notice if you received Part A services or any outpatient facility services.

MEDICARE ASSIGNMENT: Medicare Part B claims may be **assigned** or **unassigned**. Providers who accept **assignment** agree to accept the Medicare approved amount as total payment for covered services. Medicare pays its share of the approved amount directly to the provider. You may be billed for unmet portions of the annual deductible and the coinsurance. You may contact us at the address or telephone number in the Customer Service Information box on the front of this notice for a list of **participating providers** who always accept assignment. You may save money by choosing a participating provider.

Doctors who submit **unassigned** claims have not agreed to accept Medicare's approved amount as payment in full. Generally, Medicare pays you 80% of the approved amount after subtracting any part of the annual deductible you have not met. A doctor who does not accept assignment may charge you up to 115% of the Medicare approved amount. This is known as the Limiting Charge. Some states have additional payment limits. The NOTES section on the front of this notice will tell you if a doctor has exceeded the Limiting Charge and the correct amount to pay your doctor under the law.

YOUR RESPONSIBILITY: The amount in the **You May Be Billed** column is your share of cost for the services shown on this notice. You are responsible for:

- **annual deductible:** the first **$100** of Medicare Part B approved charges each calendar year,
- **coinsurance:** 20% of the Medicare approved amount, after the deductible has been met for the year,
- the amount billed, up to the **limiting charge**, for unassigned claims, and
- charges for services/supplies that are **not covered** by Medicare. You may not have to pay for certain denied services. If so, a NOTE on the front will tell you.

If you have supplemental insurance, it may help you pay these amounts. If you use this notice to claim supplemental benefits from another insurance company, make a copy for your records.

WHEN OTHER INSURANCE PAYS FIRST: All Medicare payments are made on the condition that you will pay Medicare back if benefits could be paid by insurance that is primary to Medicare. Types of insurance that should pay before Medicare include employer group health plans, no-fault insurance, automobile medical insurance, liability insurance and workers' compensation. Notify us right away if you have filed or could file a claim with insurance that is primary to Medicare.

YOUR RIGHT TO APPEAL: If you disagree with what Medicare approved for these services, you may appeal the decision. You must file your appeal within **120 days of the date of this notice**. Follow the appeal instructions on the front of the last page of the notice. If you want **help with your appeal**, you can have a friend or someone else help you. There are also groups, such as legal aid services, that will provide free advisory services if you qualify. You may contact us for the names and telephone numbers of groups in your area. To contact us, please see our Customer Service Information box on the front of this Summary Notice.

HELP STOP MEDICARE FRAUD: Fraud is a false representation by a person or business to get Medicare payments. Some examples of fraud include:

- offers of goods or money in exchange for your Medicare Number,
- telephone or door-to-door offers for free medical services or items, and
- claims for Medicare services/items you did not receive.

If you think a person or business is involved in fraud, you should call Medicare at the Customer Service telephone number on the front of this notice.

INSURANCE COUNSELING AND ASSISTANCE: Insurance Counseling and Assistance programs are located in every State. These programs have volunteer counselors who can give you free assistance with Medicare questions, including enrollment, entitlement, Medigap, and premium issues. If you would like to know how to get in touch with your local Insurance Counseling and Assistance Program Counselor, please call us at the number shown in the Customer Service Information box on the front of this notice.

Helpful Contacts For Medicare Claims & Appeals

Social Security Administration (for Medicare eligibility, enrollment, and premium payment)

www.ssa.gov
(800) 772–1213

Centers for Medicare & Medicaid Services (CMS)

www.medicare.gov
www.cms.gov
(800) 633–4227 (800-Medicare)

CMS Regional Office

Centers for Medicare & Medicaid Services (CMS)
Region IX Office
75 Hawthorne St., Suite 408
San Francisco, CA 94105–3901
(415) 744–3602

Part A Intermediaries

United Government Service, Medicare Claims and Medicare as Secondary Payer
P.O. Box 9140
Oxnard, CA 93031–9140
(866) 380–4745 (providers)
(866) 804–0684 (beneficiaries)

Mutual of Omaha Insurance
P.O. Box 1602
Medicare Division
Omaha, NE 68101
www.mutualofomaha.com
(877) 647–6528

Part B Carriers

National Heritage Insurance Company (NHIC)
www.medicarenhic.com

For Southern California (Imperial, Los Angeles, Orange, Santa Barbara, San Diego, and Ventura counties)

National Heritage Insurance Company
1055 West 7th Street, 5th Floor
Los Angeles, CA 90017
(213) 593–6000
(800) 675–2266

For Northern California (all other counties, including Riverside and San Bernardino)

National Heritage Insurance Company
450 Otterson Drive
Chico, CA 95927
(530) 896–7000
(800) 952–8627

Part B Durable Medical Equipment Regional Carrier (DMERC)

CIGNA
Medicare Administration
P.O. Box 690
Nashville, TN 37202
www.cignamedicare.com
(800) 899–7095

Medicare Quality Improvement Organization (QIO) for quality of care complaints, fast-track appeals

Lumetra (formerly known as California Medical Review, Inc., or CMRI)
1 Sansome St., Suite 600
San Francisco, CA 94104–4448
www.lumetra.com
(800) 841–1602
(415) 677–2000

Medicare Qualified Independent Contractor (QIC) (external review of Medicare fee-for-service appeals)

Maximus/Center for Health Dispute Resolution (CHDR)
Eastgate Square
50 Square Drive, Suite 210
Victor, NY 14564
www.medicareappeals.com
Fax: (585) 425-5292
Ph: (585) 425-5210

Medicare Independent Review Entity (IRE)

(external review of Medicare Advantage and Part D appeals)

Maximus/Center for Health Dispute Resolution (CHDR)
Eastgate Square
50 Square Drive, Suite 210
Victor, NY 14564
www.medicareappeals.com
Fax: (585) 425-5292
Ph: (585) 425-5210

Insurance Oversight (for most Medigaps)

California Department of Insurance
Consumer Services Division
300 S. Spring St., South Tower
Los Angeles, CA 90013
www.insurance.ca.gov
(800) 927–4357

HMO Oversight (for certain Medigaps; not for Medicare Advantage HMOs)

California Department of Managed Health Care
980 Ninth St., Suite 500
Sacramento, CA 95814–2725
www.hmohelp.ca.gov
(888) 466–2219

Medi-Cal Program

California Department of Health Services (DHS)
P.O. Box 942732
Sacramento, CA 94234–7320
www.dhs.ca.gov
(800) 952–5294 (Medi-Cal third-party liability (to remove record of M+C enrollment)
(916) 552–9432 (Medi-Cal eligibility)
(916) 552–9797 (Medi-Cal benefits)

[This Page Intentionally Blank}

Chapter 7
Medicare Supplemental Coverage

I. Introduction

The term "Medicare Supplement" technically applies only to a certain type of coverage that supplements Medicare and is one of the standardized policies established by federal Medicare law, or one issued before 1992. Generally, health insurance provided by an employer, former employer or through a union is not a Medicare Supplemental policy. It may act in a way that supplements Medicare, but does not have to comply with the requirements that apply to Medicare Supplements. This chapter covers Medicare Supplemental policies only.

A Medicare Supplement, often referred to as a "Medigap plan," is designed to cover the Medicare co-payments and deductibles a Medicare beneficiary must otherwise pay. This type of coverage is purchased by people with Medicare because it pays costs after Medicare pays. Most of the services not covered by Medicare are also not covered by a Medigap plan. The types of services covered by Medicare and beneficiaries' costs for such services are discussed in Chapters I – IV.

When evaluating any Medigap plan, beneficiaries and their advocates should remember that it is designed to cover health care expenses that are paid by Medicare, and does not include most services that Medicare does not cover. Medicare currently pays less than 50 percent of the total health care bill for people covered by this program, although that percentage will increase when the new Medicare for prescription drugs begins in 2006.

II. Standardized Medigap Plans

A. Basic Benefits

In compliance with federal and California law, companies may offer no more than ten standardized Medigap policies, labeled A – J. Companies will be able to offer two new Medigap plans K and L, beginning in the fall of 2005. They will be designed differently than the first ten plans. See the charts of Medigap Plans at the end of this chapter. All A-J standardized plans must provide benefits for the following, which together are known as the core benefits:

- beneficiary coinsurance for hospital days 61 – 90;
- beneficiary coinsurance for each of the 60-hospital lifetime reserve days;
- 100 percent of the cost for hospital care beyond the 150 Medicare-covered days in a benefit period, up to a maximum of 365 days;
- the first three pints of blood; and
- the beneficiary Part B 20 percent coinsurance of the Medicare Approved amount. (Plans K and L will only pay a portion of this cost until the annual out of pocket maximum is reached)

NOTE: *Plans K and L are discussed separately.*

Standardized Plan A has only the core benefits shown above. All other plans must include the core benefits, and also offer some additional benefits. Companies selling Medicare Supplement coverage must always make Plan A available.

B. Additional Benefits In Plans B – J

In addition to the basic benefits, plans B – J cover one, or a combination of, the following Medicare beneficiary costs. (Plans K and L are discussed separately).

Hospital First-Day Deductible – Medicare requires beneficiaries to pay a first-day hospital deductible for each "benefit period." This Medigap benefit covers the total cost of the hospital deductible.

Skilled Nursing Facility (SNF) Coinsurance – Medicare covers the full cost of a Medicare covered stay for the first 20 days of SNF care. The beneficiary pays a daily co-payment for days 21 – 100. This benefit covers the cost of the co-payment when the stay is covered by Medicare. Neither Medicare nor any of the Medigap plans provides coverage for SNF care after 100 days in a benefit period. If Medicare does not cover the nursing home stay, neither will the Medigap plan.

Note: *Most seniors who require long-term care need personal care rather than skilled, nursing care. Even when Medicare beneficiaries do meet the program's strict requirements for skilled nursing home care, the average length of a SNF stay that is covered by Medicare is ten to 12 days.*

Part B Deductible – This benefit covers the annual Part B deductible.

Note: *This benefit costs about as much in added premium as the benefit pays each year.*

80 percent or 100 percent of Part B Excess Charges – Depending on the Medigap plan chosen, this benefit pays 80 percent or 100 percent of the Part B physician charges that exceed the Medicare-approved amount. For example, if Medicare approves $100 of a $115 doctor bill, this benefit will pay either an additional $12 (if the 80 percent benefit is chosen) or the full $15 (if the 100 percent benefit is chosen). Medigap plans A through J pay 100 percent of the beneficiary's coinsurance, which is 20 percent of the Medicare approved amount.

Note: *When deciding whether or not to purchase this added benefit, beneficiaries should remember that many physicians take assignment, which means that they accept the Medicare approved amount as payment in full. When doctors do not take assignment, Medicare*

limits their charges to 15 percent above the Medicare-approved amount.

Foreign Travel Emergencies – Medicare usually does not cover care provided outside the United States, except in extremely limited circumstances. The foreign travel benefit covers 80 percent of the costs of emergency care provided outside the United States during the first two months of travel, after the beneficiary pays a $250 deductible. This benefit pays a lifetime maximum of $50,000.

Note: *This benefit is not medical insurance to protect beneficiaries who regularly live or travel outside of the United States for more than two months each year. Medigap Plans A and B do not have this benefit.*

At-Home Recovery – This benefit provides payment of $40 a visit for a maximum of 40 visits per year for doctor-ordered custodial care in the home, if the beneficiary has also received Medicare-approved skilled home health care. This benefit can be used to supplement the Medicare benefit, or to replace it for up to eight weeks after the Medicare coverage ends.

Note: *This benefit will help beneficiaries who need short-term assistance associated with receiving skilled care in order to remain in their homes. In some cases, Medicare also provides non-skilled help in the home if the beneficiary is receiving skilled home care. This benefit can be used by persons who need help, following an accident or illness, with activities of daily living such as personal hygiene, eating, and dressing.*

Preventive Care – The preventive care benefit pays a maximum of $120 a year for physician-ordered preventive care and services that are not covered by Medicare such as a routine annual physical examination.

Note: *This benefit is limited to a maximum of $120 per year. Beneficiaries may want to check with their doctors about charges for the various services and tests covered by this benefit, since Medicare is covering an increasing number of preventive services.*

Outpatient Prescription Drugs: Basic and Extended Coverage – *This benefit cannot be sold after 12/31/05.*

Basic Coverage pays 50 percent of prescription drug costs after the beneficiary pays a $250 deductible, up to a maximum benefit of $1,250 per year. For example, if a beneficiary uses $6,250 worth of prescription drugs each year, this plan will pay $1,250.

Extended coverage pays 50 percent of prescription drug costs after the beneficiary pays a $250 deductible, up to a maximum benefit of $3,000.

Note: *These prescription drug benefits cannot be sold beginning in 2006. However, some people may decide to keep their benefit even after the new Medicare Part D benefit begins in 2006. Companies will be required to renew Medigap policies with these benefits as long as the premiums are paid, but the premiums are likely to cost more and go up quickly with each passing year. People should carefully consider all the consequences of keeping this benefit after 2005.*

C. Benefits of Medigap Plans K and L

These plans are designed differently than the first ten plans. Both K and L pay a percentage of certain costs and each Plan has an annual out of pocket limit. The insured person pays their share of each cost until the maximum out of pocket limit is reached. Once the out of pocket limit has been paid, each plan pays 100 percent of all covered costs for the rest of the year. These plans are usually shown on the second page of the ten standard plans that are part of each Medigap company's sales material.

Plan K pays the following benefits:

100 percent of the following costs:

- The hospital coinsurance from day 61 through day 150;
- An additional 365 lifetime hospital days;

- All Medicare covered Part B preventive care co-insurance (after the Part B deductible is met)

50 percent of the following costs:

- The Part A deductible
- The skilled nursing co-insurance
- The Hospice co-insurance or co-payments
- The blood deductible (under Part A and Part B)
- The Part B 20 percent co-insurance

The beneficiary also pays 50 percent of the same covered costs. The annual out of pocket limit is met when the insured person has paid a total of $4,000 in covered costs. Once the annual limit of $4,000 has been reached Plan K pays 100 percent of all covered costs for the rest of that calendar year. Costs for services not covered by Plan K, such as excess charges, do not count towards this annual out of pocket limit. The Part B deductible is an exception, and although not covered by Plan K it does count towards the annual out of pocket expenses.

Plan L pays the following benefits:

100 percent of the following costs:

- The hospital coinsurance from day 61 through day 150
- An additional 365 lifetime hospital days
- All Medicare covered Part B preventive care services (after the Part B deductible is met)

75 percent of the following costs:

- The Part A deductible
- The skilled nursing co-insurance
- The hospice coinsurance or co-payments

- The blood deductible (under Part A and Part B)
- The Part B 20 percent co-insurance

The beneficiary pays 25 percent of the same covered costs. The annual out of pocket limit is met when the insured person has paid a total of $2,000 in covered costs. Once the annual limit of $2,000 has been reached Plan L pays 100 percent of all covered costs for the rest of that calendar year. Costs for services not covered by Plan L, such as excess charges, do not count towards this annual out of pocket limit. The Part B deductible is an exception, and although not covered by Plan L it does count towards the annual out of pocket expenses.

D. High Deductible Options

The Balanced Budget Act of 1997 allows companies to offer a high deductible option in Plans F and J. The high deductible option covers the same benefits as Plans F and J, respectively, except an annual deductible must be met before the plan will pay benefits. This deductible amount increases each year. The current amount is shown in the chart at the end of this chapter. The premiums for the high deductible plans are lower than those for the standard plans F and J. Few companies offer this high deductible option.

NOTE: *The annual high deductible amount does not include the deductible for the drug benefit in Plan J or the deductible for the foreign travel benefit. Each of these deductibles applies separately for each of those benefits when they are used.*

E. Comparing The Costs Of Plans Offered By Different Insurance Companies

Because Medigap benefit packages are standardized, comparing the cost of policies is basically a matter of comparing the premiums charged by various insurance companies for a particular plan based on the age, gender and zip code of an individual.

Companies generally use three different ways to set premiums for Medigap plans:

- "Community age" rating assigns one premium rate for everyone in a geographic area, regardless of individual age.
- "Issue age" rating assigns a premium based on the person's age at the time the Medigap plan is purchased.
- "Attained age" rating assigns a premium based on the person's current age; thus, the premium automatically increases as the person grows older in addition to any other increases. Premiums that are based upon attained age sometimes increase every year, and sometimes increase once every five years as a person's age changes or they move from one age group to another.

In addition to increases in premiums based upon age, premiums for all Medigaps also generally increase along with increases in the cost of medical care and inflation.

Medigap plans must meet minimum loss ratio standards. A loss ratio is the amount of money a policy pays out in claims in proportion to the amount it collects in premiums at some point in time during the life of the policy. For example, a company that has a loss ratio of 65 percent on a particular plan must pay out $65 in claims for every $100 it receives in premiums. Individual Medigap plans must meet a loss ratio of at least 65 percent; group plans must meet a loss ratio of at least 75 percent.

F. Medicare Select Plans

Medicare Select plans are a hybrid plan, combining a Medigap plan and a Preferred Provider Organization (PPO). PPOs are groups of providers (hospitals and physicians) who contract with companies to provide care at reduced rates. Generally, those who use the plan's preferred providers have lower out-of-pocket medical costs. A Medicare Select plan covers the same benefits as other Medigap plans although the benefit packages will vary from the standard plans. Medicare beneficiaries may pay a reduced premium for a Medicare Select plan and have lower out of pocket costs as long as they obtain their medical care from the providers in the PPO network. In rural

areas in particular there may not be any local community hospitals in the PPO network. Counselors should carefully compare the requirements of a Medicare Select Medigap plan with those that don't require the use of a network. Only a few companies sell Medicare Select plans in California.

The California Department of Insurance publishes a Medigap Guide on their Web site, **www.insurance.ca.gov**, which lists every company offering Medigap plans in California along with sample premiums. A paper copy of this Guide may be ordered, free of charge, from the California Department of Insurance by calling 1-800-927-HELP (1-800-927-4357).

III. Consumer Rights Regarding The Purchase Of A Medigap Plan

A. Open Enrollment Period

Companies cannot refuse to sell any Medigap plan they have available to an individual who is 65 or older during the first six months following enrollment in Medicare Part B. This is often referred to as the "six-month open enrollment period." This is an important protection. At most other times, companies can refuse to sell a Medigap plan to someone if they have a pre-existing health condition the company is unwilling to accept.

People younger than 65 who are eligible for Medicare because of a disability are also entitled to an Open Enrollment period when they first sign up for Part B if they do not have end stage renal disease. However, companies are only required to offer them some of the standardized Medigaps. These younger beneficiaries are limited to Medigap Plans A, B, C, F, AND one with prescription drugs at the option of the company until 2006 when the new Medicare prescription drug benefit begins. There is no restriction on the amount of premium a company may charge these younger beneficiaries.

NOTE: *Medigap companies cannot sell a prescription drug benefit beginning in 2006 and these younger beneficiaries will be restricted to Medigap plans A, B, C, F and H, I or J without drugs at the option of the insurance company. However, beginning in 2007, companies are required to add K or L as an additional choice.*

Some beneficiaries are covered by an employer sponsored plan through their own employment or that of a spouse or family member and can safely delay their enrollment in Part B when the employer plan is the primary health coverage and Medicare is secondary. When a beneficiary is 65 or older and continues to work or is covered by a working spouse's EGHP the group must have 20 or more employees. When a beneficiary is younger than 65 and covered by their own or a or a working spouse or family member's EGHP the group must have 100 or more employees. In both cases their six-month open enrollment period for a Medigap policy does not begin until the beneficiary first enrolls in Medicare Part B.

A person under age 65 enrolled in Medicare because of disability will get another six-month open enrollment period at age 65. They can choose from any of the Medigap plans on the market, usually at a much lower premium.

NOTE: *When a Medicare beneficiary loses or leaves an employer group plan they may also be entitled to COBRA coverage. An individual in this situation will have to compare the cost and coverage for both COBRA and a Medigap policy. (See Chapter 10 for more information on COBRA.) If they choose to take the COBRA coverage they will have one additional right to a Medigap policy after their COBRA benefits have been exhausted. They will not have a right to a Medigap policy if they stop paying their COBRA premiums because they could no longer afford them.*

1. Pre-existing Condition Waiting Periods

Although an insurance company may not deny coverage during an individual's open enrollment period, federal law permits companies to impose a waiting period of up to six months

before paying benefits for pre-existing conditions. This pre-existing condition must be one for which the person has received treatment during the six months prior to enrollment in the Medigap plan. However, companies must reduce that period by the number of months the person had any other health coverage, including Medicare and Medi-Cal, before the beneficiary applied for his or her Medigap plan. Most people will not have a waiting period due to pre-existing health conditions.

EXAMPLE:

Mr. K. will be eligible for Medicare, at age 63, after having received Social Security Disability Insurance for two years because of a severe heart condition that prevented him from working. Are insurance companies required to sell Mr. K. a Medigap policy?

Yes, for six months after he first signs up for Part B. When Mr. K. turns 65 he will have another six-month open enrollment period, beginning the month of his 65th birthday.

EXAMPLE:

Mrs. G. retired when she turned 65 in 2005. Her husband continues to work and they are both covered by his EGHP. Because her husband's insurance coverage is very good, Mrs. G. decided not to enroll in Medicare Part B. However, Mr. G. plans to retire next year. Mrs. G. will enroll in Medicare Part B and wants to purchase a Medicare Supplemental plan at that time. Will Medigap companies be required to sell her a policy?

Yes, Mrs. G.'s six-month enrollment period will begin when she first enrolls in Medicare Part B.

B. Guarantee Issue Protections For Beneficiaries Who Are Not In Their Six-month Open Enrollment Period

As part of the Balanced Budget Act of 1997, Congress enacted certain protections for Medicare beneficiaries enrolled in a Medicare Advantage plan that stops doing business in the geographic area in which the beneficiary lives, or following other specific events. Each year, the protections have been modified and expanded slightly. The California legislature has added some additional protections to those granted by federal law, including some that will take effect in late 2005 and others that are delayed until 2007.

Generally, these protections provide that a beneficiary may purchase certain specified Medigap plans without any medical underwriting, and without any pre-existing condition periods. This is referred to as "guaranteed issue" protection.

1. When Medicare Advantage Plans Leave the Market

When a Medicare Advantage plan, PACE[1], or Medicare Select plan stops doing business in the geographic area in which the beneficiary lives, or stops serving certain zip code areas, beneficiaries enrolled in those plans have the right to certain guaranteed issue Medigaps.

Under federal law, the beneficiary must apply for the Medigap plan within 63 days after receiving a notice that the prior plan will terminate, or within 63 days after the prior plan actually terminates. The 63 day period begins on the date of the notice when the person disenrolls from the plan before the plan benefits actually end, or on the first day following the day benefits did end. California law adds another 60 days to both periods when the plan leaving the market is a Medicare Advantage plan, giving beneficiaries a total of 123 days to choose one of these guaranteed issue Medigaps.

1. PACE is the Program for All-Inclusive Care for the Elderly, available in only a few areas in California.

Notice generally must be given by October 1 if a plan will terminate December 31 of the same calendar year. Thus, a beneficiary would have 123 days from October 1 (if that is the actual date notice of the plan termination is given) if they take action before the benefits end to disenroll from the plan. If they stay in the plan until the plan ends and go back to Original Medicare they have 123 days from December 31 to apply for a Medigap plan without health screening.

Note: *Most beneficiaries will want their new Medigap benefits to begin when they return to Original Medicare.*

In these situations, a beneficiary of any age except those under age 65 with ESRD, is entitled to guaranteed issuance of Medigap plans A, B, C, F (including high deductible F), K, or L from any company that sells one of these Medigaps where they live. Companies don't have to offer any Medigap plan they don't already sell.

2. Additional Situations That Trigger the Right to a Guaranteed Issue Medigap

In the following situations, a beneficiary of any age except those younger than 65 with ESRD, is also entitled to guaranteed issuance of Medigap plans A, B, C, F, (including high deductible F). However, they only have 63 days to apply. Companies must issue these Medigap plans at the best premium rate for that person's age, gender, marital status, and geographical location.

- When the individual moves out of a Medicare Advantage, PACE, or Medicare Select plan's geographic area.
- When the beneficiary had a Medigap plan and there is an involuntary termination of the plan because of insolvency or bankruptcy, the company violates a material provision of the plan, or misrepresents the benefits of the plan.
- When a beneficiary's current employer sponsored plan terminates or drops all the benefits that supplement Medicare,

or when the individual's COBRA coverage is terminated or exhausted.

3. Guaranteed Issue Rights During a Trial Period in a MA Plan

When a beneficiary enrolls in a Medicare Advantage plan or PACE for the very first time, they are said to be in a "trial period." A trial period lasts 12 months, except when the plan terminates coverage before the end of the trial period. In that case, the beneficiary can enroll in another Medicare managed care plan and extend their trial period for another 12 months. A beneficiary who voluntarily disenrolls before the end of their trial period (12 or 24 months) has the right to buy a guaranteed issue Medigap, but their choices will depend on their situation when they joined the Medicare Advantage plan.

- A beneficiary 65 or older who enrolled in a Medicare Advantage plan when he or she was first enrolled in Medicare Part B, or when he or she was 65 or older and had delayed enrollment in Part B while covered by an employer plan is eligible to buy any Medigap plan offered by any company.
- A beneficiary who had a Medigap policy, which he or she gave up to enroll for the first time in a Medicare Advantage plan, is eligible to buy their prior Medigap. If it is no longer available, they are eligible to buy Plans A, B, C, F, (including high deductible F), K, or L from any company that sells one of these plans.

4. Annual Open Enrollment During Birthday Month

Beneficiaries of any age who already have a Medigap, including a Medicare Select plan, are entitled to a new open enrollment period each year beginning on their birthday. The open enrollment lasts 30 days starting from the date of the person's birthday. Companies must provide information on the open enrollment period no less than 30 days prior to a beneficiary's birthday.

During this annual open enrollment, persons can apply for any Medicare Supplemental plan currently available that has benefits equal to or less than their current coverage. For example, a person who has a "C" policy can switch to another "C" policy or to an "A" or "B" policy. Companies cannot use medical screening to deny issuance of a Medigap plan during this open enrollment period.

5. Additional Guaranteed Issue Rights

Beneficiaries have six months to apply for any Medigap plan if they are 65 or older, or A, B, C, F (including high deductible F), and H, I or J without drugs at the option of the insurance company if they are younger than 65 and don't have ESRD. Medigap plans K or L will be an additional choice beginning in 2007.

- When a beneficiary's current employer sponsored plan terminates, including a retiree plan.
- When a military base closes, or a beneficiary moves, or can no longer receive their medical care at a military base.
- When a beneficiary moves out of a Medigap plan's service area and the plan is no longer able to cover their care.
- Beginning in 2007, when a Medicare beneficiary loses eligibility for Medi-Cal because of an increase in income or assets.

C. Other Consumer Protections

Federal and state laws that govern the marketing and sale of Medigap plans provide the following consumer protections in California:

- **Labeling:** A Medigap plan must be labeled "Medicare Supplemental Coverage."
- **Objective Information:** Companies must provide complete and objective information about benefits, exclusions and limitations, including an explanation of the relationship between a plan's coverage and Medicare benefits.

- **Outline Of Coverage:** At the time of application, the agent must provide the beneficiary with an outline of coverage.
- **"Guide To Health Insurance…":** At the time of application, a copy of the booklet "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" (prepared by CMS) must be given to the beneficiary.

  In the case of a "direct response issuer," where the beneficiary can apply for coverage directly to the company by mail rather than through an agent, the pamphlet will be delivered upon request.
- **Thirty-Day Examination:** Insurers must provide beneficiaries with a 30-day "examination period" during which a beneficiary may return the plan for any reason, cancel the purchase, and be refunded any premiums already paid.
- **Guaranteed Renewability:** Regardless of the beneficiary's health condition, all Medicare Supplemental policies must be guaranteed renewable, i.e., the company cannot drop coverage. The only legal grounds for which a company can cancel a Medigap are non-payment of premiums and/or misrepresentation of health information at the time of application.
- **Prevention Of Duplication:** Unless a person signs a statement that he or she plans to give up the first Medigap plan, companies are prohibited from selling a Medigap to someone who already has one. In addition, companies may not sell a Medigap to anyone who is receiving benefits from Medi-Cal with a few exceptions.
  - ◊ If the premium for the Medigap is paid by the Medi-Cal program the individual can buy any Medigap plan (for example, through the Health Insurance Premium Payment Program (HIPP).
  - ◊ If the Medi-Cal program only pays all or part of the Medicare Part B premium, the individual can buy any Medigap plan.

Note: *When a person owns a Medigap policy and becomes eligible for MediCal, companies must suspend premium payments for up to 24 months during periods of Medi-Cal eligibility, if the beneficiary makes that request. If the beneficiary loses Medi-Cal coverage within the first 24 months of their Medi-Cal eligibility, and notifies the company of its termination within 90 days, the Medigap plan must be reinstated.*

◊ A beneficiary younger than 65 who owns a Medigap policy and subsequently returns to work and is covered by an employer plan can ask to have their Medigap policy suspended indefinitely. If they later leave that employment or lose their coverage they can reinstate their previous Medigap.

Note: *When a Medigap policy with prescription drug coverage is suspended in either of the two previous examples that benefit cannot be reinstated. In those cases companies must issue a policy with benefits that are substantially equivalent to the previous policy without the prescription drug benefit.*

Note: *A person with a Share of Cost can buy a Medigap policy if they have not met that SOC at the time of application.*

To protect against duplication, at the time of application insurance agents must provide a beneficiary with a written statement on a company form which explains that Medicare beneficiaries need only one Medigap and informs the beneficiary of available HICAP services, including telephone numbers.

On the application form, after listing current health insurance coverage, including Medi-Cal, the beneficiary signs the form to indicate that he or she has read and understood the statement and that both the beneficiary and the insurance agent know what other health insurance coverage the beneficiary has.

- **Limitation On Premium Collection:** Companies and their agents are prohibited from requiring and collecting more than one month's premium at the time of application.
- **Requirement To Accurately Compare Coverage:** Companies and their agents are required to make fair and accurate comparisons of existing coverage before selling replacement coverage.
- **Medical Information At The Time Of Application:** Companies will be prohibited from requiring medical information on applications for Medigap coverage in 2007 when a person is entitled to that coverage because of Open Enrollment or a guaranteed issue event.

IV. Medigap Limitations

Medigap plans must base their coverage decisions on Medicare determinations for Medicare covered services. They cannot make separate determinations of medical necessity.

EXAMPLE 1: If Medicare determines that a particular service is not "medically necessary" and therefore is not covered, Medigap plans will also deny coverage.

EXAMPLE 2: If the Medicare-approved amount for a doctor's $150 bill is only $100, Medigap plans will pay the 20 percent coinsurance f the $100 approved amount. A few of the more expensive Medigap plans (Plans F, G ,I and J) will cover 80 percent or 100 percent of Part B "excess charges," i.e., up to 15 percent above the Medicare approved amount, which is also the maximum that doctors and some other providers can charge.

EXAMPLE 3: Medigap plans do not cover personal care services in a skilled nursing facility (SNF). Medigaps that cover the nursing home coinsurance only pay if Medicare has covered the person's care in the SNF. Thus, to be eligible for this Medigap benefit, a beneficiary must meet Medicare's strict SNF coverage requirements.

To appreciate the limited scope of this benefit, remember that the average Medicare-approved stay in a skilled nursing facility is only about ten to 12 days, and that Medicare pays in full for the first 20 days.

V. Which Plan To Choose?

The answer to this question depends on an individual's medical needs, income, concern about uncovered health care costs, and the premium costs of the different plans. The Medigap offering the greatest range of benefits may not be the best one for a particular individual. Conversely the least expensive plan with the least benefits could expose a client to uncovered costs later. Beneficiaries considering the purchase of a Medigap Plan should compare the costs and benefits of each plan before making a decision. Those who already have a Medigap may choose to keep their existing coverage or replace it with another plan. See the charts at the end of this chapter. Medigap plan information is also available on **www.medicare.gov** and the California Department of Insurance Web site, **www.insurance.ca.gov**.

Beneficiaries should ask themselves the following questions before making a decision:

1) How do my current Medigap plan compare with the plan I am considering?

2) How much do I think I will use the benefits offered by the plan?

3) Are the added benefits in some plans worth the added premium costs?

4) Will I be able to get a plan with more extensive benefits if, sometime in the future, I need additional coverage?

5) What are the premium costs for my age group?

6) Can I afford the current premium for the plan I have selected?

7) Does the policy's premium increase with age? If so, will I be able to afford the higher premium later?

8) Is my income low enough to make me eligible for Medi-Cal, or for a program such as QMB that will pay for at least some of my Medicare costs? A Medi-Cal beneficiary generally does not need a Medigap. In fact, the law prohibits insurers from selling a Medigap plan to someone who has Medi-Cal except in certain situations previously mentioned

9) Do I currently belong to, or plan to join, an HMO or other Medicare Advantage plan? Someone enrolled in an MA plan does not need a Medigap and it is against the law to sell one to an MA enrollee unless they will disenroll.

VI. Filing Medigap Policy Claims

Most companies that sell Medigap plans have the ability to receive claims data directly from Medicare electronically. Beneficiaries who sign the required authorization with the Part B carrier can have all their Part B claims sent directly from Medicare to their Medigap carrier if the company has this electronic claims capability. Part A claims may have to be filed manually with the Medigap company because there is more than one company processing those claims.

A beneficiary may also authorize a physician who takes assignment to receive payment directly from the Medigap company. Physicians who accept Medicare assignment are required to agree to this arrangement. If the Medigap company agrees, claim payment information can be sent directly from the Medicare carrier to the Medigap company electronically or by mail. The company then makes the appropriate payment to the physician and notifies the beneficiary of the transaction.

In the case of a physician who does not accept assignment, Medicare will process the claim and send the beneficiary the Medicare payment along with a Medicare Summary Notice (MSN) form. The beneficiary may then have to file a claim with the Medigap company if they have not signed the proper authorization, or the company cannot receive claims data from the Medicare carrier.

Beneficiaries with physicians who do not take assignment should:

1) Ask their Medicare supplement company to send them an authorization form or a claim form.

2) Fill out the authorization form completely and submit it to the Part B carrier, or fill out the claim form and attach copies of the relevant MSNs and itemized bills, if necessary for items not covered by Medicare. Beneficiaries should always keep their original EOMBs or MSNs and send only copies;

3) Make a copy of any claim form submitted, noting the date it was mailed; and

4) Call the company if there has been no response within 60 days.

VII. Typical Beneficiary Questions

QUESTION ONE: I just went to the doctor and he charged me $115. I submitted a claim to Medicare that approved only $100 for the service. Medicare sent me a check for 80 percent of the $100 figure. When I submitted a claim to my Medigap company for the $35 balance, my supplemental plan only paid $20. What's going on?

ANSWER: *This is a very common situation. Medigap plans base their reimbursement upon the Medicare-approved amount. In your case, the approved amount was $100. Medicare paid 80 percent of the $100, and your Medigap paid the 20 percent co-payment but not the excess charge, the additional $15.*

Some Medigap plans (Plans F, G, I and J) will also cover 80 percent or 100 percent of Part B physicians' excess charges up to 15 percent above the Medicare-approved amount. If you had one of these plans, it would have covered an extra $12 or $15 of the physician's bill.

QUESTION TWO: I was recently hospitalized for a minor heart attack. I have had a Medigap for four months and have been paying my premiums regularly. Medicare paid for most of my care, but the first-day deductible and physician co-payments added up to about $1,000. When I submitted a Medigap claim, the insurer informed me that I was not yet covered for my heart condition. Why not? I've been paying my premiums for four months.

ANSWER: *This can only happen if you did not have any medical coverage prior to taking out your Medigap policy. Look at your policy carefully. There is probably a pre-existing condition exclusion for conditions that were diagnosed or treated within six months prior to the date on which the policy was issued. If you saw your doctor about a heart condition in the six months prior to taking out the Medigap plan and had no other medical coverage during those months, the pre-existing condition clause could limit your coverage. If you did have previous coverage you need to contact the company. Companies are not allowed to impose this waiting period when an individual had previous medical coverage.*

QUESTION THREE: I have a Medigap and am thinking about doubling my protection by buying another one. Is this a good idea?

ANSWER: *No. If you have a Medigap, buying another one will simply duplicate the coverage you already have and will not add to it. In fact, unless you are planning to replace the existing plan, it is illegal for a company to sell you a second Medigap.*

QUESTION FOUR: I have a Medigap policy with the at-home recovery benefit. I needed some help with eating, dressing, and getting around the house. I hired a part-time helper but my Medigap denied my claim for reimbursement.

ANSWER: *The at-home recovery benefit will only reimburse you for this type of care if you are also receiving Medicare covered home health care. Because you had not received Medicare home health benefits, the services you received were not covered by your Medigap plan.*

MEDICARE SUPPLEMENTAL INSURANCE STANDARDIZED PLANS

	A	B	C	D	E	F[1]	G	H[2]	I[2]	J[1,2]
Basic Benefits Hospital coinsurance, days 61 – 90 and lifetime reserve days; 100% beyond Medicare covered hospital days, 365 days maximum; Part B 20% coinsurance; three pints of blood	X	X	X	X	X	X	X	X	X	X
Hospital First Day Deductible		X	X	X	X	X	X	X	X	X
SNF Co-Insurance Days 21-100			X	X	X	X	X	X	X	X
Part B Annual Deductible			X			X				X
Part B Excess Physician Charges 80% or 100% of charges over Medicare-approved amount						100%	80%		100%	100%
Foreign Travel Emergencies 80% of care during first two months of travel; $250 deductible; $50,000.00 lifetime maximum			X	X	X	X	X	X	X	X
At Home Personal Care Up to $40/visit, 40 visits/year; must be receiving Medicare covered home health care				X			X		X	X
Preventive Care $120/year for physician-ordered health screenings					X					X
Prescription Drugs 50% of outpatient prescription drug costs, $250 deductible; Basic Coverage: up to $1,250; Extended Coverage: up to $3,000								X	X	X

1. Plans F and J may also be offered with a $1,730 deductible (in 2005).
2. After January 1, 2006, plans H, I, and J can not be sold with the prescription drug benefit.

MEDICARE SUPPLEMENTAL INSURANCE STANDARDIZED PLANS

New Plans K and L

Basic Benefits for Plans K and L include similar services as plans A - J, but cost-sharing for the basic benefits is at different levels.

	K**	L**
Basic Benefits Hospital coinsurance, days 61-90 and lifetime reserve days; 100% beyond Medicare covered hospital days, 365 days maximum; Part B 20% coinsurance; three pints of blood	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare benefits end 50% Hospice cost-share 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100 % of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare benefits end 75% Hospice cost-share 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
SNF Coinsurance	50%	75%
Part A Annual Deductible	50%	75%
	$(4,000) Out of Pocket Annual Limit***	$(2,000) Out of Pocket Annual Limit***

**Plans K and L provide for different cost-sharing for items and services than plans A - J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges for your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

*** The out-of-pocket annual limit will increase each year for inflation.

Chapter 8
Medicare For People Who Are Working

I. Introduction

Many people who are age 65 or older still work or are married to someone who still works and has health insurance through employment. People with disabilities under age 65 may also have health benefits through their, or a spouse's, employment. There are a number of issues that apply to those who are eligible for Medicare and have health insurance through work. These issues include whether or not to enroll in Medicare and how Medicare coordinates with employer-based health insurance.

In the Medicare program, group health insurance offered by an employer with 20 or more employees is referred to as an "employer group health plan," or EGHP, when talking about Medicare beneficiaries who are age 65 or older. Group health benefits offered to people younger than 65 by an employer of 100 or more employees is referred to as a "large group health plan," or LGHP. The special rules discussed in this chapter apply to those who have an EGHP and are covered through their own or their spouse's current employment; certain rules also apply to those who have an LGHP and covered through their own, their spouse's or a family member's current employment. They do not apply to those who have retiree benefits from a former employer as part of retirement benefits, and they do not apply to those who have health benefits from a current employer with less than 20 employees.

II. Requirements For Employers

Employers with 20 or more employees who offer health insurance to their employees must, by law, offer the same health insurance options to employees who are age 65 or older. This includes offering health insurance to older employees' spouses if the employer offers it to younger employees' spouses. Employers with 100 or more employees must offer the same health insurance options to younger employees or their spouses who have Medicare. If the employee or spouse chooses not to enroll in the EGHP, the employer may not offer other coverage that supplements Medicare.

In addition, neither the employer nor the EGHP itself has any choice as to whether the group plan is primary or Medicare is primary. The rules are established by the federal Medicare law, and are discussed below.

III. Options For Beneficiaries With Medicare And Employer Benefits

Medicare eligible persons and Medicare eligible spouses who have an EGHP available to them have three choices as to health coverage:

1) They may opt for both their group plan and Medicare;

2) They may opt for Medicare only and decline their group plan; or

3) They may opt for their group plan only and decline Medicare Part B (Medicare Part A is given to them automatically) and is free if they have paid into the Social Security system for 40 quarters.

Note: *Individuals with prescription drug coverage through employer based plans will also have additional decisions to make concerning the new Part D prescription drug benefit. Individuals who decline Part D coverage when first eligible may have to pay a premium penalty if they later decide to enroll. In some cases, individuals will be able to delay enrollment in Part D without penalty if they already have prescription coverage that is*

considered at least as good as the new Part D benefit. See Chapter Twelve, section III. Premiums, Penalties and Creditable Coverage.

Each of these options has different consequences that should be considered in deciding which option to choose. Each option is discussed below.

A. Both Medicare And EGHP

A person who has primary employer coverage may want to delay taking out Part B of Medicare at additional premium cost. Generally, employer coverage provides a broader scope of benefits than Medicare. Having Medicare in addition to an EGHP may reduce a person's total out of pocket costs by enough to make it worth paying the Medicare Part B premium. In other cases the cost of the employer coverage may be greater than having Medicare alone. Each situation should be explored to determine the most appropriate and affordable combination.

In analyzing whether to have both the group benefits and Medicare, a person should keep in mind the fact that if an individual has both, the group plan is primary and Medicare is secondary. This means that medical bills must be submitted first to the group plan. The group plan must pay all medical claims first, without regard to whether Medicare will cover something or how much Medicare will pay. Once the group plan has processed a claim, then Medicare will process it. The rules as to how much Medicare will pay are somewhat technical and complicated, and are presented later in this chapter. If the group plan is an HMO however, and a Medicare beneficiary goes outside the plan for services, Medicare will deny benefits for services that would have been covered by the group plan.

If an EGHP denies coverage for a claim and the claim is for a Medicare covered service, Medicare will pay the claim as if the employee did not have a group plan. Medicare may assume primary responsibility in paying for a beneficiary's health care if services

furnished are not covered under the employer plan or the beneficiary has exhausted his/her benefits under the plan.

1. Medigap Considerations

A related issue which should be considered before deciding to have both a group plan and Medicare has to do with Medicare supplemental coverage. A company is required to sell a Medicare supplemental policy (also known as a Medigap plan) without medical underwriting in the first six months after a person first signs up for Medicare Part B. After this six-month period, companies can and often do refuse to sell Medigap policies to people who currently have health problems or have a history of health problems, particularly those who are younger than 65. Someone who has both an EGHP and Medicare does not need a Medigap plan. The Medigap policy would be third in line for coverage, after the primary EGHP and Medicare being secondary. It is unlikely that a Medigap policy would provide any additional benefit and even if it did, would most likely not be worth the premium it would cost. If, however a person is paying for their employer coverage and that premium is higher than it would be for Medicare and a Medigap, the person may want to drop the employer plan for the Medicare-Medigap combination. Careful consideration must be given to all the consequences of dropping employer sponsored coverage.

A person who has both an EGHP and Medicare may want to purchase a Medicare supplemental insurance policy in the future when the group plan is no longer available. If a Medicare beneficiary at any age subsequently retires or loses their employer sponsored coverage, they may be eligible for a guaranteed issue Medigap plan at that time without medical underwriting. In addition, a younger Medicare beneficiary who delayed enrollment in Part B will have a second open enrollment opportunity at age 65 when they will be guaranteed the right to buy any Medigap plan.

2. Medicare Only

The employee may decide, because of high EGHP premium costs or poor coverage, to drop the group plan and have Medicare only. The employee's spouse also has this option when he or she has Medicare.

A beneficiary who chooses Medicare only should apply for Medicare during the "initial enrollment" period, explained later in this chapter.

If the employee or spouse declines the group plan and opts for Medicare coverage only, by law the employer cannot provide a supplemental policy for Medicare-covered services. The purpose of the law is to encourage employees to continue with their EGHP, thereby shifting the cost of health care from the Medicare program to the employer plan. However, the employer can offer health insurance for services not covered by Medicare such as, dental care and routine physical examinations.

Before declining an EGHP, an employee should consider whether or not his or her spouse needs the health insurance coverage provided by the EGHP. Generally, in order for a spouse to be insured under an EGHP, the employee must also be covered by it. If a spouse is under 65 and not eligible for Medicare, the EGHP is often his or her only source of health insurance coverage. An employee generally does not want to cut off his or her spouse's insurance coverage by declining an EGHP for himself or herself.

3. EGHP Only

The employee or spouse may decide that the EGHP provides better coverage than Medicare and may choose not to pay the Medicare Part B monthly premium. In this case, the EGHP will be the person's sole health coverage.

Persons covered by an EGHP who do not want Part B benefits are free to decline enrollment when they are first eligible for Medicare.

Medicare beneficiaries may later change their minds and opt for Medicare. Beneficiaries who decide to add Medicare coverage, either while still working or when they retire, can enroll in Medicare during either a "special enrollment period" or a "general enrollment period," as described later in this chapter.

IV. When An Individual May Enroll In Medicare

When a person turns 65, he or she can apply for Medicare during the "initial enrollment" period. The initial enrollment period is a seven month period beginning three months before the month of the person's 65th birthday and ending three months after the month of the person's 65th birthday.

A person who is eligible for Medicare because of a disability can apply for Medicare during their "initial enrollment" period, which generally begins after completion of month 25 of covered Social Security Disability. Generally, a person who enrolls later than the initial enrollment period will have to pay a penalty for late enrollment.

However, employees and their spouses who receive coverage under an EGHP are not required to enroll in Medicare during their initial enrollment period. They have an additional "special enrollment period" which becomes available when the employee either retires or drops the group coverage, or when the employer discontinues the group plan.

The special enrollment period is an eight-month period, beginning the month after coverage in the EGHP ends. Thus, if the EGHP coverage ends at the end of September, the eight- month special enrollment period begins with October. If the person enrolls in Medicare during the first month of the special enrollment period, the Medicare coverage will be effective the first day of that same month. If a person enrolls in Medicare during the second through eighth month of the special enrollment period, the Medicare coverage will be effective the first of the month following enrollment.

EXAMPLE:

Mrs. Jones is 67 years old and does not have Medicare Part B. Mrs. Jones' health coverage through her EGHP ends on September 30, 2005, due to her retirement on that date. Her special enrollment period, in which Mrs. Jones may enroll in Medicare without paying any penalty for late enrollment, is from October 1, 2005 through May 31, 2006.

If Mrs. Jones enrolls in Medicare Part B in October 2005, her Medicare coverage takes effect October 1, 2005. If Mrs. Jones enrolls in Medicare in November 2005, her Medicare coverage will be effective December 1, 2005.

A person age 65 or older also has the choice of enrolling in Medicare during any annual "general enrollment period," which is January through March of every year. If a person enrolls during the general enrollment period, Medicare coverage becomes effective July 1 of that year. Unlike other Medicare beneficiaries, individuals with employer- sponsored coverage are not assessed any premium penalty if they enroll during a general enrollment period while still employed. When the Special Enrollment Period overlaps with the General Enrollment Period, the beneficiary has the choice of which to use.

Note: *The enrollment periods discussed this chapter apply to Medicare Parts A and B. For a discussion of Part D enrollment, refer to Chapter Twelve.*

V. Medicare And COBRA

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 that requires employers to provide continuation of group health benefits following certain triggering events such as job loss, death or divorce. Until June of 1998, people who were already covered by Medicare could

not take advantage of COBRA. Following a U.S. Supreme Court decision that year, people who qualify for COBRA but already have Medicare can have Medicare and COBRA benefits at the same time.

The decision to take advantage of COBRA needs the same analysis any employer sponsored health benefits would require. Often the decision to continue the employer's group health benefits with COBRA hinges on coverage of prescription drugs. Even after Medicare offers prescription drug coverage in 2006, people with Medicare may still decide to take COBRA because the prescription drug coverage of their COBRA plan is more generous than Medicare's.

One important difference is that COBRA will always be secondary to Medicare, except that the prescription drug benefits may be as good as or better than Medicare's. In that case, an individual could delay enrollment in Part D of Medicare and the COBRA prescription drug benefit would be their only coverage for that benefit. In addition, the beneficiary must make certain that the employer and the administrator of the COBRA benefits understand that Medicare is primary in order to avoid any personal liability for improperly paid claims. The fact that COBRA benefits are secondary to Medicare, except when enrollment in Part D is delayed will not reduce the amount of the premium for COBRA coverage. The beneficiary will still be responsible for 102 percent of the premium charged to the employer.

VI. Medicare As Secondary Payor

As explained earlier in this chapter, if a person has both an EGHP and Medicare, the group plan is primary and Medicare is secondary. The amount that Medicare pays as secondary payer when the group plan is a fee for service plan and the individual is enrolled in Original Medicare differs with the type of medical services. The formulas for how much Medicare will pay are presented below. The examples that follow should make it easier to understand how these formulas work.

A. Physicians' Services

For physicians' services, Medicare as secondary payer pays the lowest of the following three amounts:

1) the physician's actual charge minus the amount paid by the EGHP;

2) the amount Medicare would pay if there were no EGHP;

3) the higher of (a) the Medicare approved amount (as if there were no EGHP) or (b) the EGHP approved amount, minus the amount paid by the EGHP.

As a practical matter, the amount Medicare pays will almost always be the third amount. Therefore, Medicare will pay an amount that will bring the total reimbursement paid to the physician up to the Medicare approved amount or the EGHP approved amount, whichever is higher. As is true for all beneficiaries, before Medicare will pay anything for a Part B service, the beneficiary must meet the Medicare Part B annual deductible. However, any amounts paid by the EGHP for medical care will count towards meeting it.

B. Medicare Part A Services

For most medical care paid under Part A of Medicare such as hospital care, skilled nursing facility care and home health care, Medicare as secondary payer pays the lowest of the following four amounts:

1) the Medicare approved amount, minus any applicable Medicare deductible and coinsurance amounts;

2) the Medicare approved amount, minus the amount paid by the EGHP;

3) the lesser of (a) the actual charges or (b) the amount that the medical provider must accept as payment in full under the EGHP, minus the amount paid by the group plan; or

4) the lesser of (a) the actual charges or (b) the amount that the medical provider must accept as payment in full under the group

plan, minus any applicable Medicare deductible and coinsurance amounts.

EXAMPLE:

Dr. High charged Mr. Veatch $200 for an office visit. Mr. Veatch's EGHP approved $150 and paid 80 percent of this amount, or $120. The Medicare approved amount for this visit is $100. Mr. Veatch has already met his Part B annual deductible.

Medicare will pay the lowest of the following three amounts for Mr. Veatch's visit to Dr. High:

- *the actual charge minus the amount paid by the EGHP $200 – $120 = $80;*
- *the amount that Medicare would pay if there were no EGHP 80 percent of $100 = $80;*
- *the EGHP approved amount (since that is higher than the Medicare approved amount) minus the amount paid by the group plan $150 – $120=$30.*

Since $30 is the lowest of the three amounts, Medicare will pay $30.

VII. Questions To Consider When Deciding Whether To Choose An EGHP Only, Medicare Only, Or Both

1) Does the group plan cover benefits that are not covered by Medicare?
2) With a group plan only, how much are the person's yearly out-of-pocket medical costs including the EGHP premiums, deductible and co-payments?

3) With Medicare only, how much are the person's yearly out-of-pocket medical costs? How much are they with Medicare and a Medicare supplemental insurance policy?

4) Does the employee need to retain coverage under the EGHP because her/his spouse is under age 65 and needs insurance?

5) Does the client have any health concerns which might make it difficult to obtain Medicare supplemental insurance at a later time?

[This Page Intentionally Blank}

Chapter 9

Medi-Cal And Programs To Help With Medicare Costs

I. Introduction

Many Medicare beneficiaries have difficulty paying the out-of-pocket costs associated with Medicare. Medicaid, known as Medi-Cal in California, provides health coverage for certain low-income persons and also helps with Medicare cost sharing for low-income Medicare beneficiaries. The Medicare Modernization Act of 2003 (MMA), which added a new prescription drug benefit under Part D, imposes significant changes for people who are dually eligible for Medicare and Medi-Cal ("dual eligibles"). Dual eligibles, who currently access prescription drug coverage though Medi-Cal, will no longer have access to such coverage through Medi-Cal at the end of 2005, and will instead have to be enrolled in a Medicare Part D plan in order to have prescription coverage.

Several other government programs pay all or a portion of the Medicare costs for low-income Medicare beneficiaries. These programs are known as the Medicare Savings Programs (MSPs). The MMA also created a program – the low-income subsidy (LIS) – to help pay for expenses under the new Part D prescription drug benefit. Medi-Cal, MSPs, and the LIS are all discussed in this chapter.

II. Medi-Cal

Medi-Cal is a government program, funded jointly by the federal government and the State, which provides health coverage for low-income children, families, and certain adults.

In California, applications and eligibility for Medi-Cal are handled by the local offices of each county's Department of Public Social Services (DPSS). The California State agency that is responsible for administering the Medi-Cal program is the Department of Health Services (DHS).

A. Eligibility For Medi-Cal

A number of different categories of people are eligible for Medi-Cal. The information presented here focuses only on those who might be HICAP clients – Medicare beneficiaries, such as the elderly and younger individuals who are disabled – and does not include other categories such as young families with children.

Medicare beneficiaries who might be eligible for Medi-Cal are elderly persons, age 65 or older, and younger adults who are blind or disabled. In order to be considered disabled, a person must be expected to be unable to do any work, i.e. engage in substantial gainful activity, for a period of at least 12 months or to suffer from a condition that is expected to result in death. Medicare beneficiaries who qualify for Medi-Cal must meet specific income and resource (or asset) requirements. The income and asset rules for qualifying for Medi-Cal for individuals are different than those for married couples. The major programs through which Medicare clients may be eligible for Medi-Cal are outlined below.

1. Supplemental Security Income (SSI)

Elderly and disabled Medicare beneficiaries who qualify for Supplemental Security Income (SSI) are automatically eligible for Medi-Cal. A separate application for Medi-Cal is not required. Medicare beneficiaries apply for SSI at local Social Security offices. To qualify for SSI, Medicare beneficiaries must meet SSI income and resource requirements. These guidelines are outlined in the chart titled "Medi-Cal Eligibility: Supplemental Security Income (SSI)" at the end of this chapter.

2. Aged and Disabled Federal Poverty Level (A&D FPL) Program

As of January 1, 2001, a State program called the Aged and Disabled Federal Poverty Level (A&D FPL) program provides Medi-Cal coverage to elderly and disabled persons who meet the SSI resource limits, but have incomes that are higher than SSI limits. The income requirements for the A&D FPL program are outlined in the chart titled "Medi-Cal Eligibility: Aged and Disabled Federal Poverty Level Program (A&P FPL)" at the end of this chapter.

3. Medi-Cal With a Share of Cost

Medicare beneficiaries whose incomes are above both the SSI and the A&D FPL program requirements may qualify for Medi-Cal with a monthly share of cost (SOC). These individuals must meet the SSI resource limits outlined in the chart titled "Medi-Cal Eligibility: Supplemental Security Income (SSI)" at the end of this chapter.

The Medi-Cal share of cost functions like a medical insurance deductible. The individual or married couple must spend their monthly income down to the allowed monthly amount before Medi-Cal will pay for any remaining medical expenses that month. The amount a person must "spend down" must be spent on medical expenses, and is called their "share of cost." The share of cost is not a monthly premium. It must only be met or spent down in the months when medical expenses occur. Persons who receive Medi-Cal with a share of cost are also sometimes referred to as "medically needy."

To determine eligibility for Medi-Cal with a share of cost, the individual or married couple's income is compared to the State's Maintenance Need Levels. The current Maintenance Need Levels are listed in the chart titled "Medi-Cal Eligibility: Medi-Cal Share of Cost" at the end of this chapter.

4. In Home Supportive Services (IHSS)

Frail and disabled individuals who meet the eligibility requirements for SSI, the Aged and Disabled FPL program or Medi-Cal Share of Cost may be eligible for assistance in the home through In-Home Supportive Services (IHSS). IHSS provides non-medical services, including household and related chores, paramedical services, protective supervision, personal care services and transportation to medical appointments, for low-income individuals who are functionally impaired and cannot remain safely in their homes without these services.

In each county, the local offices of each county Department of Public Social Services (DPSS) handle applications and eligibility for In-Home Supportive Services. A person who qualifies for IHSS is automatically eligible for Medi-Cal.

5. Medi-Cal Long Term Care

The Medi-Cal Program pays for custodial long term care in a nursing facility. In order to qualify, a person must be aged (65 years or older), blind or disabled. The eligibility rules for Medi-Cal long term care for a single person are different than those for a married couple.

An unmarried person in a nursing home may be eligible for Medi-Cal if he or she meets the Medi-Cal resource requirements (outlined in the chart titled "Medi-Cal Eligibility: Income and Resource Guidelines" at the end of this chapter). With regard to income requirements, a Medi-Cal long term care resident is allowed to keep a personal needs allowance of $35 per month. All income above the personal needs allowance must be paid to the nursing facility as the resident's "share of cost."

The rules are very different for a married couple with one spouse in a nursing home and the other spouse at home. The spouse at home is allowed to keep a significant amount of income and assets and still have the nursing home spouse qualify for Medi-

Cal. The intent is to protect the "at-home spouse" from becoming impoverished. The dollar amount that the at-home spouse may keep changes each year.

Medi-Cal Long Term Care	Income Limit	Resource Limit
Single aged or disabled person in a nursing home	$35 per month	$2,000
Aged or disabled married couple, one in a nursing home		
• At home spouse	$2,378 per month	$95,100
• Nursing home spouse	$35 per month	$2,000

1. If the excess above this amount is spent on medical care, the person/couple may still qualify for full Medi-Cal.

6. Issues Relating To Medi-Cal Eligibility For Long Term Care

a. Transfer of Assets

Many older adults would rather leave an estate for their children or other family members than use their money and resources to pay for nursing home care.

Some have tried to manipulate their finances shortly before going into a nursing home. Others may have transferred assets or restructured their finances for purposes unrelated to Medi-Cal eligibility, and then later found themselves in the position of needing nursing home care and trying to qualify for Medi-Cal. Such situations are generally referred to as "transfer of assets."

If a person in a nursing home has transferred (or given away) assets for less than fair market value up to 30 months before applying for Medi-Cal, he or she may be subject to an indefinite period of ineligibility. The number of months of

ineligibility is computed by dividing the fair market value of the transferred assets by the average monthly private pay nursing home rate.

There are several exceptions to the transfer of assets rule. For instance, there is no penalty for transfers made to:

1) a spouse;

2) a minor or disabled child;

3) a sibling with an equity interest in the home who has lived there for at least one year immediately before the person went into the nursing facility; or

4) an adult child who has lived in the home for at least two years and cared for the Medi-Cal applicant.

b. Liens on Homes and Estate Claims

People are often concerned that they may lose their home if they apply for Medi-Cal. Another common concern is that the State (which administers the Medi-Cal program) will take their estate when they die, leaving no money for their heirs. Generally, a person's home will be considered exempt from Medi-Cal eligibility rules, as long as a beneficiary expresses an intent to return home in the Medi-Cal long term care application. In most instances, the law no longer allows Medi-Cal to place a lien against a person's home.

However, after a person dies, the State may try to recover the amount the Medi-Cal program paid for that person's care after the person turned 55, or for a person at any age who received benefits in a nursing home, if the person does not have a surviving spouse, or a surviving blind, disabled or minor child.

c. Trusts and Annuities

Some insurance agents and financial planners may encourage seniors to set up trusts, purchase annuities or otherwise

restructure their finances in order to keep their assets and still qualify for Medi-Cal. In magazines and newspapers targeting seniors, some attorneys advertise a one-size-fits-all trust document for a relatively low fee. Insurance agents, financial planners and attorneys sometimes sponsor seminars, using a room at a local bank or other community location. The use of a rented room, or even sponsorship by a bank does not necessarily mean that the institution endorses the person, product or idea. It also does not mean that the person is reputable or knows the subject matter.

People attending these seminars should consult with their own accountant or financial planner before making any changes in their financial plans. Otherwise, they may be taking the risk that Medi-Cal will not pay for their long-term care for some period of time, and they may no longer have the funds to pay for it themselves.

B. Medi-Cal Benefits

Medi-Cal pays for health care services that meet its definition of "medically necessary." Covered services include hospitalization, physicians' care, x-ray and laboratory services, nursing home care, adult day health care, home health care, eyeglasses, ambulance services, prosthetic and orthopedic devices, hearing aids, some dental care, medical equipment and prescription drugs. Some services are covered by Medi-Cal only if prior authorization, called a Treatment Authorization Request or TAR, is obtained from the physician. No prior authorization is needed for emergency care.

When a person is in a nursing home, Medi-Cal covers the cost of the nursing home stay including all of the medical services and care received during that stay. In contrast to Medicare, Medi-Cal covers nursing home care for persons who only need custodial care as well as for persons who need skilled care. In fact, Medi-Cal is the primary source of payment for nursing home care.

To receive Medi-Cal benefits, the person must use providers, including pharmacies, who accept Medi-Cal. When using Medi-Cal providers, a person can only be billed for a $1 pharmacy co-payment and a $5 emergency room co-payment. Otherwise, no other out of pocket costs may apply. When a person is found eligible for Medi-Cal, a Benefits Identification Card (BIC) is issued to that individual. Persons must show their BIC to providers when seeking medical services. The BIC provides proof of Medi-Cal eligibility and allows providers to bill Medi-Cal for the services.

C. How Medi-Cal Coordinates with Medicare

Individuals who have both Medicare and Medi-Cal are often referred to as "dual eligibles" or "Medi-Medis." Medi-Cal pays the Medicare Part B premium and covers the Medicare co-payments and deductibles for persons who have Medicare and Med-Cal benefits. Persons who have Medicare and Medi-Cal with a share of cost, must meet their share of cost before Medi-Cal will pay any Medicare co-payments and deductibles. Medi-Cal will pay the Medicare Part B premium whether or not the share of cost is met.

Persons who have both Medicare and Medi-Cal use Medicare as their primary coverage and Medi-Cal as their secondary coverage. In fact, Medi-Cal is known as the "payor of last resort", meaning that it will only pay after all other applicable insurances.

In addition, Medi-Cal has traditionally provided benefits not covered by Medicare such as prescription drugs, dental and vision care services. As discussed below, however, Medi-Cal will no longer cover prescription drugs for dual eligibles as of January 2006.

D. How Medicare And Medi-Cal Benefits Coordinate With Medicare Advantage Plans

When an individual who has Medicare and Medi-Cal benefits joins a Medicare Advantage HMO, they must receive all Medicare covered services through the HMO by using the HMO network of doctors and hospitals. Medicare Advantage HMO members can obtain Medicare

covered services outside the HMO only if they need emergency or urgent care.

Beginning in January 2001, the Department of Health Services began paying the Medicare Advantage HMO monthly premiums for members who were also on Medi-Cal (including Medi-Cal share of cost) if their HMO offered a prescription drug benefit. The State of California does not plan to continue this premium payment program, however, once the new Medicare Part D prescription drug benefit takes effect in 2006.

Persons who have Medicare and Medi-Cal can use their Medi-Cal coverage outside the Medicare Advantage plan only in the following situations:

- The individual has exhausted the HMO benefit and Medi-Cal offers additional benefits. For example, the person exhausts his HMO prescription drug coverage for the year and uses Medi-Cal to obtain additional drug coverage (note: this will no longer apply to drug benefits beginning January 2006)
- The individual uses Medi-Cal to obtain a health benefit not covered by the Medicare Advantage plan. For example, the person uses his Medi-Cal coverage to obtain dental benefits because the HMO does not cover dental care.

Most Medicare Advantage plans charge their members HMO co-payments when services are used. Persons who have Medicare and Medi-Cal who are also Medicare Advantage members do not have to pay these co-payments if the services are provided by HMO providers who are also Medi-Cal providers. In practice, however, such individuals are often inappropriately charged co-payments for these services.

E. Dual Eligibles & Part D

1. Overview

As discussed above, individuals who are dually eligible for Medicare and Medi-Cal have traditionally received their prescription drug coverage from the Medi-Cal program. The Medicare Modernization Act (MMA), however, imposes a fundamental change in prescription drug coverage for this group. Starting in 2006, dual eligibles can no longer get most prescription drugs through the Medi-Cal program. In order to obtain prescription drug coverage, dual eligibles must be enrolled in a Medicare Part D plan.

In order to prevent a gap in drug coverage between the end of Medi-Cal coverage and the beginning of Part D, dual eligibles are automatically enrolled into a Part D plan, if they do not choose one themselves, by January 1, 2006. Dual eligibles are also automatically eligible for financial assistance with Part D costs – the low-income subsidy, discussed below. In addition, they are not going to be "locked in" to their plans over the course of a year, as are other Part D and Medicare Advantage enrollees. Despite these protections, however, many advocates fear that dual eligibles will end up with less prescription drug coverage under Part D, more out-of-pocket costs, and less protection during drug appeals than they have had under Medi-Cal.

2. Coverage

Prior to the implementation of Part D, people with both Medicare and Medi-Cal have access to the broad Medi-Cal formulary that covers virtually all prescription drugs. Under Part D, however, these dual eligibles are restricted to the formularies of whatever Part D plan they are enrolled in. For a discussion of Part D plan coverage, including formularies, see Chapter Twelve. The State of California plans to continue covering certain drugs for dual-eligibles that have been covered by Medi-Cal, but are not covered

under Part D (namely, benzodiazepines, barbiturates and certain over the counter drugs).

3. Auto-Enrollment into Part D Plans

In 2005, in order to prevent a gap in drug coverage between the end of Medi-Cal coverage and the beginning of Medicare Part D, dual eligibles will be automatically enrolled into a Part D plan, if they do not choose one themselves, by January 1, 2006. Individuals who are dual eligibles in 2005 will receive a notice from CMS in October 2005 informing them which plan they will be enrolled in, effective January 1, 2006. If a dual eligible does not select a plan on their own, they are randomly assigned to a Part D plan that has average or below premiums for the region.

Dual eligible individuals who are enrolled in a Medicare Advantage (MA) plan that offers any prescription drug coverage as of December 31, 2005, are enrolled into that same organization's MA prescription drug plan (MA-PD) effective January 1, 2006,, even if the monthly premium exceeds the low-income premium subsidy amount (discussed below). This means that the individual will be responsible for the increased premium amount.

In 2006 and beyond, for individuals who become dually eligible for Medicare and Medi-Cal on or after January 1, 2006, CMS will automatically enroll them into Part D plans. The timing of such enrollment depends on when an individual is first eligible for either Medicare or Medi-Cal. Individuals who are Medi-Cal eligible and subsequently become newly eligible for Medicare Part D on or after January 1, 2006, will be automatically enrolled in a Part D plan by CMS on the first day of the month they are eligible for Part D. Conversely, individuals who are eligible for Medicare Part D and subsequently become newly eligible for Medi-Cal on or after January 1, 2006, will be automatically enrolled in a Part D plan within the first few months of their dual eligibility, if they do not select a plan themselves.

Unlike other Part D and MA enrollees, dual eligibles will not be "locked-in" to their plans over the course of a year – they will have an ongoing special enrollment period (SEP) allowing them to switch plans on a monthly basis.

Dual eligibles will be automatically enrolled into the Part D low-income subsidy (LIS). See below for a discussion of dual eligibles and the LIS.

III. Medicare Savings Programs That Help Pay Medicare Out Of Pocket Costs

Congress has established several programs to help low-income people with the costs associated with Medicare. The programs sound very similar, but each has slightly different income or resource criteria and each pays for a different combination of Medicare cost sharing. To participate in any of these programs, an individual must have Medicare Parts A and B. These programs are officially referred to as the Medicare Savings Programs (MSPs) and sometimes as the "buy-in" programs, because they "buy-in" to Medicare for people with low incomes.

The Medicare Savings Programs are administered by the same agencies that administer the Medi-Cal program. Thus, in order to obtain the benefits of any of these buy-in programs, an application must be submitted to the local Medi-Cal office, i.e. the county Department of Public Social Services. Those who have not already enrolled in Medicare must also submit an application for Medicare to their local Social Security Office at the same time.

Beneficiary advocates report that many people experience problems obtaining the benefits of these programs. There are often glitches in the coordination between the various government agencies that are involved, many Medi-Cal workers are not familiar enough with the Medicare Savings Programs, and clerical errors can be difficult to track down and

correct. Thus, obtaining the benefits of these programs can often be a challenging and frustrating experience and can require perseverance.

Each of these programs is discussed below.

A. Qualified Medicare Beneficiary (QMB)

The Qualified Medicare Beneficiary (QMB) program is for Medicare beneficiaries with low incomes and with resources that are double the SSI/Medi-Cal limits. Their incomes can be no higher than the federal poverty level, which is adjusted every April 1. The income amounts and resource limits for the current year are reflected in the chart titled "Medicare Savings Programs: Income and Resource Guidelines" at the end of this chapter.

Under the QMB program, the state pays the Part A premium for those not automatically eligible for Part A, the Medicare Part B premium, and all Medicare deductibles and co-payments. The QMB program is the only program that pays the Medicare Part A premium. Therefore, this program can provide that important benefit for persons such as legal immigrants or others who do not qualify for free Part A. Individuals must apply for Part A first through Social Security and then for the QMB program through their county Medi-Cal office. They should state on their application that they want Part A only if the State finds them eligible for QMB to pay the premiums; otherwise, they could be charged for Medicare Part A.

In California, there are many people who qualify for QMB and Medi-Cal due to the similar income and resource requirements. Given that the scope of Medi-Cal benefits is greater than QMB, (Medi-Cal pays the Part B premium, the Medicare cost sharing, and offers additional benefits,) persons should be encouraged to apply for Medi-Cal too, if they appear eligible. (Note: Medi-Cal does not pay the Part A premium.)

B. Specified Low Income Medicare Beneficiary (SLMB)

The Specified Low Income Medicare Beneficiary (SLMB) program is available to Medicare beneficiaries whose incomes are no higher than 120 percent of the federal poverty level. The federal poverty level changes every year and the SLMB income levels and resource limits are set forth in the chart titled "Medicare Savings Programs: Income and Resource Guidelines" at the end of this chapter. The resource requirements are the same as for QMB, however, in contrast to the QMB program, the only Medicare cost that SLMB pays is the Part B premium.

C. Qualifying Individual (QI)

The QI program is available to those Medicare Beneficiaries whose incomes are between 120 percent and 135 percent of the federal poverty level. See the chart titled "Medicare Savings Programs: Income and Resource Guidelines" at the end of this chapter for the QI income and resource limits. For those who meet the QI criteria, the State will pay their Medicare Part B premiums in full. This is the only Medicare cost that the QI program pays. The QI program, while scheduled to expire every few months, continues to be renewed.

D. Qualified Disabled And Working Individuals (QDWI)

The Qualified Disabled and Working Individuals (QDWI) program is available to persons who had Social Security and Medicare because of disability, but have lost their Social Security benefits due to earnings that exceed the "substantial gainful activity" limit for disability benefits. Such persons are still allowed to purchase Medicare.

Under the QDWI program, the State pays the Medicare Part A premium for these disabled individuals. To qualify for the QDWI benefit, a person's monthly income cannot exceed 200 percent of the federal poverty level. For the income and resource limits, see the chart titled "Medicare Savings Programs: Income and Resource

Guidelines" at the end of this chapter. QDWI does not pay for the Medicare Part B premiums.

Disabled individuals in the category described above who do not meet QDWI's income and resource limits are entitled to Medicare Parts A and B, but must pay their own premiums.

IV. Medicare Part D & The Low-Income Subsidy (LIS)

In addition to creating the new Part D prescription drug benefit, the Medicare Modernization Act provides extra help with the cost of Medicare Part D prescription drugs for people with low incomes who meet the income and asset qualifications. This extra help is also known as the "low-income subsidy" (LIS) program.

A. Eligibility

1. Dual Eligibles

People who have both Medicare and Medi-Cal don't need to apply for the low-income subsidy because they will receive it automatically. Medicare will send them a letter before September 2005 about their automatic enrollment.

While dual eligibles will face limited cost-sharing because of their eligibility for the low-income subsidy (and the institutionalized will face no cost-sharing), their choice of plans will be effectively limited. Dual eligibles will be restricted to low-income premium benchmark plans if they want to avoid paying any Part D plan premium. There is no guarantee that individual drug needs will be met by these plans.

People who have Medi-Cal with a Share of Cost (SOC) must meet their share of cost before they are considered a "full dual eligible" and deemed eligible for the low-income subsidy. When a person meets their share of cost for the first time during the year, they will continue to qualify for the lower cost-sharing for Medicare

covered prescription drugs for the rest of that calendar year. If an individual meets his/her share of cost late in a year, the person may be deemed eligible for the entire next year. Individuals do not have to keep spending down each month to remain LIS eligible for the calendar year, however, they will need to spend down each month to access their other Medi-Cal benefits.

If an individual's share of cost is met from:	The individual is deemed eligible for the LIS for:
March 2005 – Dec 2005	All of 2006
Jan 2006 – Aug 2006	The remainder of the 2006 calendar year
Sept 2006 – Dec 2006	The remainder of the 2006 calendar year, plus all of 2007

2. Medicare Savings Program Enrollees

People with Medicare who don't qualify for Medi-Cal but are enrolled in one of three Medicare Savings Programs, will also automatically get the new Part D low-income subsidy. These Medicare Savings Programs include the following: Qualified Medicare Beneficiaries (QMB); Specified Low-Income Medicare Beneficiaries (SLMB); and Qualified Individuals (QI). People who are enrolled in the Qualified Disabled and Working Individual program (QDWI) will not be automatically enrolled into the low-income subsidy.

Unlike people who have both Medicare and full Medi-Cal, these beneficiaries won't be automatically assigned to a Part D plan. Instead, they must actively choose and enroll in a Part D plan. If they have not selected a Part D plan by May 2006, they will be enrolled (or "facilitated") into one.

3. Other Low-Income Individuals

Other Medicare beneficiaries with incomes below 150 percent of the federal poverty level (FPL) see chart titled "Part D Low Income Subsidy" at the end of this chapter) and who meet certain asset tests can apply for the low-income subsidy at their local Social Security or Medi-Cal offices. If they apply at the Medi-Cal office, they should also be screened for other programs they may qualify for at the same time (such as Medi-Cal and the Medicare Savings Programs).

Beneficiaries will also be able to apply for the low-income subsidy through Social Security over the phone (800-772-1213) and on the Social Security Web site at **www.socialsecurity.gov**. The subsidy won't begin until beneficiaries sign up for a Part D plan and are eligible to begin receiving benefits. The earliest Part D benefits can begin is January 1, 2006.

For a breakdown of income limits and corresponding benefits under the low-income subsidy, see the see the chart titled "Part D Low Income Subsidy" at the end of this chapter.

B. Benefits

Individuals who are eligible for the low-income subsidy will be entitled to different benefits, based upon their income and assets. See chart titled "Part D Low Income Subsidy" at the end of this chapter. For a description of Part D benefits, see Chapter 12. In general, LIS enrollees will pay either a limited or zero premium and limited or no cost-sharing.

Except for the people who fall into the highest income and asset group (up to 150 percent of the federal poverty level), qualified beneficiaries won't have to pay a premium for the plan they choose or are assigned to unless the premium is higher than the low-income subsidy. The low-income subsidy will cover the premiums of Part D plans that charge no more than the average Part D premium for other plans in a person's area. This is referred to as the

benchmark premium. If the plan's premium is more than the subsidy, beneficiaries can pay the difference between the subsidy and the plan's premium, or they can enroll in another plan that has a premium at the same price or lower than the subsidy amount.

Nursing home residents (institutionalized) on Medi-Cal have no cost-sharing under the low-income subsidy.

C. Facilitated Enrollment

While full dual eligibles will be automatically enrolled into Part D plans, all other low-income subsidy enrollees will have to choose their own Part D plans. If low-income subsidy enrollees (other than dual eligibles) have not chosen a plan by May 2006, CMS will "facilitate" their enrollment into a Part D plan by randomly assigning them to a plan. Individuals who enroll in the low-income subsidy after May 2006 will also be "facilitated" into plans if they do not choose plans themselves. However this process could take some time. Low-income subsidy enrollees should be encouraged to choose a plan within permissible enrollment periods.

V. HICAP Counselors' Role In Counseling Clients On Eligibility For Medi-Cal Programs

The purpose of this chapter is to provide HICAP counselors with the training necessary to assist clients with information on Medi-Cal and the other programs that help pay Medicare costs. HICAP counselors should screen clients for eligibility for these programs. Screening should normally be limited to a general discussion of the eligibility requirements for these programs. HICAP counselors should refer clients who are potentially eligible and interested in applying for these programs to the appropriate county Department of Public Social Services (DPSS) office.

HICAP counselors should not try to conclusively determine a client's eligibility for these programs or help clients fill out applications. The information and charts provided in this chapter are designed to help counselors make appropriate referrals to the DPSS office only. Lastly,

HICAP counselors should not attempt to respond to client questions that fall outside the scope of HICAP training, such as how to spend down resources in order to qualify for Medi-Cal.

Medi-Cal Eligibility
Income And Resource Guidelines
Year 2005

Supplemental Security Income (SSI)	Income Limit	Resource Limit
Single aged or disabled person	$812 per month	$2,000
Aged or disabled married couple	$1,437 per month	$3,000

Medi-Cal Aged and Disabled FPL Program	Income Limit	Resource Limit
Single aged or disabled person	$1,028 per month	$2,000
Aged or disabled married couple	$1,437 per month	$3,000

Maintenance Needs Levels for Medi-Cal (Share of Cost)	Income Limit	Resource Limit
Single aged or disabled person	$600 per month[1]	$2,000
Aged or disabled married couple	$934 per month[1]	$3,000

Medi-Cal Long Term Care	Income Limit	Resource Limit
Single aged or disabled person in a nursing home	$35 per month	$2,000
Aged or disabled married couple, one in a nursing home		
• At home spouse	$2,378 per month	$95,100
• Nursing home spouse	$35 per month	$2,000

1. If the excess above this amount is spent on medical care, the person/couple may still qualify for full Medi-Cal.

NOTE: *Certain items are excluded from being counted as income or resources. See the chart at the end of this chapter.*

Medi-Cal Eligibility
Supplemental Security Income (SSI)
2005 Income And Resource Guidelines

Supplemental Security Income (SSI)	Income Limit	Resource Limit
Single aged or disabled person	$812 per month	$2,000
Aged or disabled married couple	$1,437 per month	$3,000

Income Limits

To assess a person's eligibility for Medi-Cal, we must calculate the individual or couple's countable income and compare it to the SSI income guideline. To calculate countable income, the following amounts are subtracted from the reported gross income.

- 20 standard deduction
- $65 per month of earned income plus one-half of the remaining earnings

EXAMPLE:

Bob is a 54 years old and has Medicare because he is receiving Social Security disability. Bob is single and his gross income before his Medicare Part B premium is taken out of his Social Security check is $760 per month. Is Bob eligible for SSI?

Gross Income	$760
Subtract $20 standard deduction	$ 20
Bob has no earned income	$ 0
Net countable income	$740

Resource Limits

The following resources are not counted toward the resource limits.

- the home
- one car
- burial plot and funds (unlimited irrevocable or $1500 if revocable)
- household goods and personal effects
- life insurance with face value of up to $1500

Medi-Cal Eligibility
Aged & Disabled Federal Poverty Level (FPL) Program
2005 Income And Resource Guidelines

Aged & Disabled FPL Program	Income Limit	Resource Limit
Single aged or disabled person	$1,028 per month	$2,000
Aged or disabled married couple	$1,437 per month	$3,000

Income Limits

To assess a person's eligibility for Medi-Cal, we must calculate the individual or couple's countable income and compare it to the Aged and Disabled FPL income guideline. To calculate countable income, the following amounts are subtracted from the reported gross income.

- 20 standard deduction
- $65 per month of earned income plus one-half of the remaining earnings

EXAMPLE:

Susan is 74 years old and a widow. She receives $900 per month in Social Security benefits before her Medicare premium is deducted. Susan owns her home and has $4000 in the bank. Is Susan eligible for Medi-Cal under the A&D FPL program?

Gross Income	$760
Subtract $20 standard deduction	$ 20
Susan has no earned income	$ 0
Net countable income	$740

Resource Limits

The following resources are not counted toward the resource limits.

- the home
- one car
- burial plot and funds (unlimited irrevocable or $1500 if revocable)
- household goods and personal effects
- life insurance with face value of up to $1500

Medi-Cal Eligibility
Medi-Cal Share of Cost
2005 Income And Resource Guidelines

Medi-Cal Share of Cost Limit	Income Limit	Resource Limit
Single aged or disabled person	$600 per month	$2,000
Aged or disabled married couple	$934 per month	$3,000

Income Limits

To assess a person's eligibility for Medi-Cal, we must calculate the individual or couple's countable income and compare it to the SSI income guideline. To calculate countable income, the following amounts are subtracted from the reported gross income.

- 20 standard deduction
- $65 per month of earned income plus one-half of the remaining earnings

EXAMPLE: *George and Marie are married and both are over the age of 65. They have no resources. George and Marie receive $1200 per month in Social Security benefits. Are they eligible for Medi-Cal with a share of cost?*

Gross Income	$1200
Subtract $20 standard deduction	$ 20
George and Marie have no earned income	$ 0
Net countable income	$1180

The Medi-Cal share of cost is calculated by subtracting the current Maintenance Need Level from the net countable income.

Net countable income	$1180
Subtract the Maintenance Need Level	-$934
Medi-Cal share of cost	$246

Resource Limits

The following resources are not counted toward the resource limits.

- the home
- one car
- burial plot and funds (unlimited irrevocable or $1500 if revocable)
- household goods and personal effects
- life insurance with face value of up to $1500

Medicare Savings Programs
Income And Resource Guidelines
Year 2005

Program	Covered Medicare Expenses	Income Limit Per Month	Resources Limit
Qualified Medicare Beneficiary (QMB)	Parts A and B premiums, deductibles and co-payments	$798 (individual) $1,070 (couple)	$4,000 (individual) $6,000 (couple)
Specified Low-Income Medicare Beneficiary (SLMB)	Part B premium	$957 (individual) $1,283 (couple)	$4,000 (individual) $6,000 (couple)
Qualifying Individual	Part B premium	$1,077 (individual) $1,444 (couple)	$4,000 (individual) $6,000 (couple)
Qualified Disabled and Working Individual (QDWI)	Part A premium	$1,595 (individual) $2,139 (couple)	$4,000 (individual) $6,000 (couple)

NOTE: *Certain items are excluded from being counted as income or resources. See the chart at the end of this chapter.*

Eligibility For Medi-Cal And Medicare Savings Programs Exclusions From Income And Resources

The following amounts or items are not counted in determining whether a person's or couple's income and resources exceed the income and resource limits listed in the prior two charts for purposes of determining eligibility for Medi-Cal, QMB, SLMB and QDWI (all of these programs are described earlier in this chapter).

Income Exclusions:

- First $20 of unearned income;
- First $65 of earned income;
- One-half (½) of earned income above the first $65 received during the month;
- SSI payments;
- Value of food stamps received;
- For disabled persons, impairment-related work expenses.

Resource Exclusions:

- The full value of the person's residence;
- One car;
- Household goods and personal belongings;
- Burial plot;
- Prepaid burial plan (unlimited if irrevocable, up to $1,500 if revocable);
- Life insurance up to a cash value of $1,500 per person
- For six months after receipt, retroactive Social Security or SSI benefits.

Low Income Subsidy (Extra Help)
Income and Resources Guidelines
Year 2005

If You Have...	Your Assets	You Pay
Medi-Cal and your income is <u>below</u> 100% of the federal poverty level (FPL): • $9,570 a year for an individual; and • $12,830 a year for a couple in 2005	Are below : • $2,000 for individuals and • $3,000 for couples	• No monthly premium[1] • No deductible • $1/generic and $3/brand-name *(no co-pay after $5,100 in total annual drug costs. Total cost equals the amount covered by the Part D plan and co-payments) (Note: people with Medi-Cal who are living in a nursing home, including those who have met their SOC, will have no drug co-pays)*
Medi-Cal and your income is <u>above</u> 100% of the FPL: • $9,570 a year for an individual; and • $12,830 a year for a couple in 2005	Are below : • $2,000 for individuals and • $3,000 for couples	• No monthly premium[1] • No deductible • $1/generic and $3/brand-name *(for people on Medi-Cal through the Aged & Disabled FPL program)* • $2/generic and $5/brand-name *(including for people who have met their Medi-Cal SOC) (no co-pay after $5,100 in total annual drug costs)*
Medicare Savings Programs (QMB, SLMB, and QI) and your income is between 100% – 135% of the FPL: • $9,570 – $12,920 a year for an individual; and • $12,830 – $17,321 a year for a couple in 2005	Are below : • $4,000 for individuals and • $6,000 for couples	• No monthly premium[1] • No deductible • $1/generic and $3/brand-name *(for people with QMB)* • $2/generic and $5/brand-name (for people with SLMB or QI) *(no co-pay after $5,100 in total annual drug costs)*
DON'T have Medi-Cal and your income is below 135% of the FPL: • $12,920 a year for an individual and • $17,321 a year for a couple in 2005	Are below[3]: • $6,000 for individuals and • $9,000 for couples	• No monthly premium[1] • No deductible • $2/generic and $5/brand-name *(no co-pay after $5,100 in total annual drug costs. Total cost equals the amount covered by the Part D plan and co-payments)*
DON'T have Medi-Cal and your income is below 150% of the FPL: • $14,355 a year for an individual; and • $19,245 a year for couple in 2005	Are below[3]: • $10,000 for individuals and • $20,000 for couples	• Sliding scale monthly premiums[2] • $50 deductible • 15% coinsurance *($2/generic and $5/brand-name co-pay after $5,100 in total annual drug costs. Total cost equals the amount covered by the Part D plan, the deductible, monthly premiums and 15% coinsurance)*

1. The low-income subsidy will cover the premiums of Part D plans that charge no more than the average Part D premium for other plans in a person's area.
2. People who have incomes below 135 percent of the FPL and assets between $6,000 and $10,000 for individuals and $9,000 and $20,000 for couples will have no monthly premium. They will have a $50 deductible and pay 15 percent coinsurance.
3. These asset figures DON'T include the additional money allowed for covering burial expenses ($1,500 for individuals and $3,000 for couples).

Chapter 10
Other Health Care Coverage

I. Introduction

There are some health insurance categories that are important for HICAP clients, but that do not fit neatly into any of the other subjects presented in this manual. One such category is a person's right to continue employer based health coverage when it stops. Another is the availability of health coverage for those individuals who are not low-income but who would not otherwise be able to obtain insurance because of health problems or pre-existing conditions. The last such category discussed in this chapter is health coverage for low-income adults who do not qualify for Medi-Cal or Medicare and have no other health insurance.

II. Continuation Of Employer Based Coverage

A person's right to continue employer based coverage when it would otherwise end stems from a federal law known as the Consolidated Omnibus Reconciliation Act of 1986, and is commonly referred to as "COBRA." It applies to employers with 20 or more employees. In California, employers with two to 19 employees must provide the same protections under CalCOBRA. All of these rights are grouped together and discussed in this chapter.

A. Who Is Entitled To Continuation Coverage

Any individual covered by employer based group health insurance must be allowed to continue that insurance if the health coverage ends because of any of the following circumstances:

1) the death of the covered employee;

2) the termination, retirement (other than for gross misconduct) or reduction in hours of the covered employee;

3) the divorce or legal separation of the spouse from the covered employee;

4) the covered employee drops the coverage due to becoming eligible for Medicare;

5) a dependent child loses his or her dependent status.

If the employer switches health insurers, the replacement health insurance must be offered to employees entitled to COBRA or CalCOBRA coverage. However, if an employer no longer offers its employees any group health plan, there is no plan to offer the former employee or spouse and COBRA or CalCOBRA coverage ends.

If a person eligible for COBRA or CalCOBRA becomes eligible either for other group health insurance or for Medicare, that eligibility ends the person's right to health coverage through COBRA or CalCOBRA. If the person already had Medicare before losing the group coverage, then he or she still has the right to purchase COBRA coverage, but not CalCOBRA. The length of the COBRA coverage that is available is discussed in the next section.

Eligibility for a program in California entitled Senior CalCOBRA, which applied to individuals who worked for their employer for at least five years and were age 60 or older, ended prior to 2005.

B. Length Of Continuation Coverage

The length of time for which a person may purchase continuation coverage differs depending on several circumstances. These include the reason the employer based coverage ended, the person's subsequent entitlement to Medicare, and the person's age at the time of losing the employer coverage. Generally, the length of time a person is entitled to continuation coverage is either 18, 29 or 36 months. The varying lengths of time and the circumstances to which each applies are set forth in a chart at the end of this chapter.

A person who has Medicare and later loses his or her group health coverage does have the right to COBRA coverage, but not CalCOBRA. If the person loses group health coverage because he or she terminates the job or reduces the hours worked within the first 18 months of having Medicare, then the person has the right to COBRA for a period of 36 months from the date the person first has Medicare. If the person loses group health coverage because he or she terminates the job or reduces the hours worked after having Medicare for at least 18 months, then the person has the right to COBRA for a period of 18 months.

California law extends COBRA coverage for California residents to a maximum of 36 months if COBRA coverage was for a shorter period of time.

C. Cost Of Continuation Coverage

The individual who chooses to continue the employer based coverage will be required to pay the entire premium, plus an administrative fee that may not exceed a set percentage of the premium. The amount that may be charged differs depending on several factors, and is contained in a chart at the end of this chapter. Since the health coverage is simply continuing, there are no exclusions for pre-existing conditions. The coverage remains the same as for other employees, and the price of the premium is regulated. Although the price of COBRA coverage may seem high, in many cases it costs less than an

individual policy, for which premium rates are not regulated. If the individual fails to pay any of the premiums on time, however, he or she loses the right to continue COBRA coverage.

D. Continuation At The End Of Cobra

Federal law requires companies selling health benefits in the individual market to sell one to a person who is exhausting their COBRA coverage. These are referred to as HIPAA continuation policies for the federal legislation entitled the Health Insurance Portability and Accountability Act of 1996. Companies are required to sell a person who is exhausting their COBRA coverage one of their two most popular plans. Although there is some state control on the premiums, these are very expensive policies that many people are unable to afford even though companies are required to issue them.

III. The Medically Uninsurable

California has a state subsidized insurance program for people who cannot obtain adequate medical coverage because of pre-existing conditions. (Although employer based group health coverage can not refuse to insure anyone on the basis of their health condition or health history, companies offering individual coverage may do so). This insurance program is known as the Major Risk Medical Insurance Program, or MRMIP (pronounced "Mr. Mip").

To be eligible for health coverage through MRMIP a person must be:

- a California resident;
- not eligible to purchase COBRA or CalCOBRA coverage;
- been denied coverage, involuntarily terminated, or quoted a premium higher than MRMIP; and
- not eligible for both Medicare Part A and B, unless eligible solely because of ESRD.

NOTE: *Not eligible for both parts of Medicare means those people who must purchase Part A. As a practical matter only those who are legal residents and are not eligible for premium-free Medicare, and those people with ESRD who are on Medicare, are the only two groups of people who can belong to MRMIP.*

MRMIP provides a maximum of $75,000 total benefits annually, and $750,000 in a lifetime. This program can only accept a limited number of enrollees and the premiums can be very expensive. The waiting list to obtain coverage through MRMIP can be long. Becoming eligible for Medicare, except for ESRD, makes a person ineligible for MRMIP. Someone who is covered by COBRA or CalCOBRA must exhaust those benefits before they are eligible for MRMIP, but they can sign up early to try and coordinate the end of COBRA with MRMIP enrollment. People who voluntarily drop their COBRA or CalCOBRA are not eligible for MRMIP.

Benefits are provided through a limited number of health plans that enrollees choose when they are accepted. There is usually a choice between Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). HMOs can require a fixed dollar for some services and up to 20 percent co-payment for others. PPOs can also require a fixed dollar co-payment for some services and up to 25 percent for others. The annual co-payment maximum in recent years has been $2,500 for individuals and $4,000 for families. Because the program is subsidized by the state these amounts can change periodically.

Premiums are adjusted by the state annually in January. The premium is based on the age of the applicant. Birthdays can move the applicant and any family members into a new rate category.

The program is limited to three years, after which enrollees graduate to a private, but still subsidized private insurance plan. The benefits of the plan have to be comparable to the benefits of MRMIP and the premiums are generally about ten percent higher.

Anyone who is interested in additional information regarding MRMIP or in submitting an application for it should contact MRMIP at 1-800-289-6574.

IV. The Uninsured

Many Californians do not have health insurance. They do not have employer-based health insurance, are not eligible for Medicare or Medi-Cal, and either cannot afford or cannot obtain private insurance.

In California, county-administered health care facilities are required by law to provide low-cost and/or free care to people who have no other source of health coverage and are very low-income. All county-run health care facilities provide screening to determine eligibility for free or low-cost care.

Maximum Length Of Continuation Coverage

Reason Health Coverage Ends	Who May Continue Coverage	Maximum Time Coverage May Continue
Employment terminates or hours reduced	Employee Spouse Dependent Child	18 months[1]
Employment terminates or hours reduced, and person has had Medicare for 18 months or less	Employee Spouse	36 months from date person first has Medicare
Employment terminates or hours reduced, and person has had Medicare for more than 18 months	Employee Spouse	18 months
Divorce or legal Separation from covered employee	spouse dependent child	36 months
Death of covered employee	spouse dependent child	36 months
Employee drops coverage because enrolls in Medicare	spouse dependent child	36 months
Loss of dependent child status	dependent child	36 months

1. If the former employee is determined by Social Security to have been disabled within the first 60 days of COBRA coverage, then COBRA may be extended for up to an additional 11 months, for a maximum total of 29 months.

Maximum Charge For Continuation Coverage

Circumstance	Premium
Employer has 20 or more employees	102% of the premium amount
Employer has 2 – 19 employees	110% of the premium amount
For months 19 – 29 of coverage, if coverage is extended because of disability (regardless of number of employees)	150% of the premium amount
For extended continuation coverage beyond that provided by COBRA or CalCOBRA (beyond the 18 or 36 months period)	If the premium charged the employer is based on the person's age: • 102% of the premium amount if 20 or more employees; • 110% of the premium amount if 2 – 19 employees If the premium charged the employer is NOT based on the person's age: • 213% of the group premium divided by the number of covered persons

Chapter 11

Long Term Care Insurance

I. Introduction

One method of paying for long term care is an insurance policy specifically designed to pay for long term care. California state law spells out certain standards companies must meet to sell their products in our state. Long term care insurance (LTCI) was originally designed to pay benefits only for care in skilled nursing facilities (commonly called "nursing homes"). Many policies today pay benefits for a wide range of services including home care, community-based care and assisted living, as well as skilled nursing facility care. As with most other forms of insurance, it cannot be purchased once a person needs the benefits. This chapter is a brief primer on this type of insurance.

II. Federally Qualified Long Term Care Insurance

In 1996, Congress passed a new law called the Health Insurance Portability and Accountability Act, or HIPAA. Part of this law, effective in 1997, gave a tax break to people who buy certain long term care insurance (LTCI) policies that meet minimum federal standards. Premiums for these LTCI policies may be tax deductible and the benefits paid by these policies are not taxable as income. Policies that qualify for the new tax break are labeled as "Federally Qualified" policies and must use a strict standard of eligibility for benefits.

The federal law does not mention tax deductions or exemptions for LTCI policies that do not meet the federal standards. This created a problem for states like California that had higher eligibility standards than the federal law provided.

The eligibility standard for policies that were being sold in California was less strict than the federal standards, which for example made home care benefits easier to get. Lawmakers in California did not want to change state law to make benefits harder to get, even if there was a tax advantage to the purchasers of those policies. To resolve the conflict, California required companies to sell both types of policies in California. That requirement expired in 2002. Californians can still buy either a federally qualified LTC insurance policy, or a non-qualified policy that meets California's eligibility standards, although today most companies only sell tax qualified policies. Even though the requirement to sell a policy with the California eligibility standard has expired, companies must still meet all other standards in state law.

People who buy federally qualified policies may be able to deduct some or all of the LTCI premium as a medical expense on their federal and state tax returns, depending on their age and adjusted gross income (AGI). To take this deduction, they must first itemize their medical expenses on their federal and state tax returns, which few people do. In order to claim a tax deduction, a person's total medical expenses, including the LTCI premium must be greater than 7.5 percent of the person's AGI. Only the amount that exceeds 7.5 percent of the person's AGI may be deducted. Thus, a fairly large amount of medical expenses is usually needed in order to qualify for this tax deduction. In addition, benefits paid by these policies will be excluded from a person's taxable income.

People who bought non-qualified policies beginning in 1997 when HIPAA took effect cannot deduct their premiums. However, the IRS has not made any ruling as to whether any part of the benefits paid out by a non-qualified LTC policy are taxable. Policies sold before 1997 under state law were "grand-fathered in" and are deemed to be tax-qualified.

The premiums for those policies are deductible and the benefits non-taxable. People who have questions or want assistance with this tax issue should consult their tax advisor.

NOTE: *According to many financial advisors, most seniors need either high medical expenses or $30,000 in annual income before itemizing deductions on a federal tax return will outweigh the benefits of the standard deduction. However, the rising cost of Medicare Part B premiums and new premiums for Medicare Part D combined with premiums for a long term care policy may result in more people claiming a medical deduction in the future.*

III. How Long Term Care Insurance Is Designed

Long-term care insurance can pay benefits for various types of care received in a variety of locations:

- in institutions like skilled nursing facilities or residential care facilities for the elderly;
- at home, through home health care, personal care and homemaker services;
- hospice care;
- respite care; and
- in the community, such as adult day care, adult day health care, or Alzheimer's day care.
- Some LTCI policies cover most of these types of care or services, while some LTCI policies cover only one or two kinds. The type of care that people generally need in any of these locations is assistance or supervision with the normal activities of daily living (ADLs), or supervision because of a cognitive disorder like Alzheimer's disease. Medicare generally does not pay for this type of care, but LTC insurance policies frequently do.

In California, companies can sell only three types of policies:

- a nursing home only;
- a home care only; or a
- comprehensive policy (that pays in a wide variety of places).

Beginning July 2001 a nursing home only policy changed to a Nursing Home And Residential Care Facility For The Elderly Policy to reflect the requirement that such policies include benefits for assisted living services in these facilities. Aside from these three basic types, however LTCI policies can be sold with many features.

A single company can sell any or all three types of LTCI policies. Also, any of the three can be sold as a federally tax-qualified policy ("tax-qualified" TQ,) or as a policy that is not federally tax qualified ("non-tax-qualified" NTQ).

Unlike Medigap policies, long term care insurance policies are not standardized, making them difficult to compare. A single company can sell many different versions of these policies, including some that meet the federal requirements and others that do not. It is possible for one company to have dozens of different LTCI policies in their portfolio. Companies can also stop selling a particular policy and replace it with another that is very similar, almost any time they choose to do so. Each policy, regardless of the type or the company selling it, has certain common features, which are discussed below.

Each long-term care policy also contains a variety of terms that are defined in the policy. Some definitions are required by state law, while others are left up to each company. Adults of all ages and even some professionals have difficulty understanding these policies. Unfortunately, some people do not understand exactly what their policy will cover until they file a claim for benefits.

IV. Common Features Of Long Term Care Insurance

Each policy, regardless of the type, has some features that are likely to be common to all long-term care insurance policies. These include:

- a daily benefit that will be paid;
- a deductible or an elimination period;
- a maximum number of years or dollar amount of benefits; and
- inflation protection.

The choices someone makes about these items, plus the age of the person applying for coverage, and sometimes their health condition, will determine the premium a person pays for a long term care insurance policy.

Following is a short discussion of some of the more important features that are likely to be common to all long-term care insurance policies. However, companies can add many different features and provisions to a long term care policy. Each policy is unique to that company and the design the company is selling at that particular time, and the laws that were in effect at the time or the laws of the state where it was issued.

A. The Daily Benefit

Most policies pay a specific dollar amount each day (sometimes called a "daily benefit" or "daily maximum") that ranges from $50 a day to more than $200 a day for the services described in the policy. This means that the company will pay covered expenses up to the daily maximum that was chosen at the time the LTCI policy was purchased. The policyholder will be responsible for any amounts greater than the daily benefit and the company will not pay more than the cost of the covered service, even if it is less than the daily benefit.

Some companies define the exact amount that they will pay for each service. Sometimes these amounts are expressed as a dollar amount; other times they are defined as a percentage of the daily nursing home

benefit. Some companies combine the daily amount and pay a weekly or monthly benefit for all covered services for as long as the person continues to need care. This option allows more flexibility to arrange the appropriate amounts of care and type of services each week or each month.

> ***EXAMPLE:***
>
> *Mrs. Smith bought a policy with a daily benefit of $100 for each day of nursing home care. If the nursing home billed $150 each day, the policy would only pay the maximum daily benefit of $100, leaving a co-payment of $50 a day (equal to $1,500 a month) for Mrs. Smith to pay. Conversely, if the nursing home billed $85 a day, Mrs. Smith would only get the actual cost of $85 a day, not the maximum of $100 per day.*

Companies are required to allow the entire lifetime maximum to be used for any of the institutional, home care, and community care benefits covered by the policy. These are called interchangeable or integrated benefits. The amount of the daily benefit for different services can still be limited, but companies cannot limit one part of the total benefit amount to home care and another part to institutional care.

B. Duration Of Coverage

Most policies have a maximum number of years that benefits will be paid once the company starts paying at the highest daily benefit amount. This time period is sometimes called a "lifetime benefit period," "maximum benefit period" or "lifetime maximum." Others refer to it as the duration of coverage, measured in the total number of years or the total amount of dollars that a company will pay. Now that companies have to fully integrate their benefits, the number of years benefits will be paid depends on the daily amount that is being paid.

EXAMPLE:

Mr. C. has a one-year LTCI policy that pays $100 per day for nursing home care and $50 per day for home care.

If only the nursing home benefit is used, the policy will pay $100 per day for one year (365 days), or a total of $36,500. ($100/day x 365 days = $36,500).

Because the insurance company must fully integrate the types of benefits, it must allow the same dollar amount of benefits for home care as for nursing home care. Thus, if only home care benefits are being used, the policy could pay for up two years. ($36,500 ÷ $50/day = 730 days or two years).

Companies generally sell coverage in amounts that equal one year of benefits paid at the highest daily amount. When people purchase a policy, they choose the number of years they want the policy to pay. Policies can pay for one, two, or more years once benefits begin. Some companies sell lifetime coverage that will pay benefits no matter how long the person lives after benefits begin. Generally, the longer the company agrees to pay benefits, the higher the premium, and not many people can afford the premium for lifetime coverage once they reach age 65. Most people buy between two and five years of coverage.

C. Elimination Or Waiting Period

This is the total number of days a person must wait after qualifying for benefits before the policy will begin paying benefits. It acts like a deductible. Elimination periods are chosen at the time a LTCI policy is purchased. Most policies offer a range of elimination periods including a zero waiting period that pays benefits from the first day a person qualifies for benefits. The most common waiting periods are 30, 60, or 100 days. The premium will be lower if a longer elimination period is chosen, but the insured person will be responsible for the full cost of care throughout the entire period.

EXAMPLE:

The cost of a nursing home is $100 per day and Mrs. Smith has a 60-day waiting period. When she goes into a nursing home, she will have to pay the first $6,000 ($100 per day x 60 days) before the policy will pay anything.

If Mrs. Smith is in the nursing home longer than 60 days, the policy will begin paying on day 61. If she is in the nursing home for only 50 days, the policy will pay nothing for that nursing home stay.

Remember that Medicare pays for nursing home stays only in very limited situations, and generally only for very limited periods of time. It is extremely rare for Medicare to pay the maximum 100 days that it is allowed to cover. Furthermore, when Medicare does pay, the patient has a very significant co-payment for each of days 21 -100.

LITTLE KNOWN FACT: *Federally tax qualified policies are not allowed to pay the Medicare coinsurance after day 21, and are not allowed to pay any benefits as long as Medicare is paying for the person's care. Non-tax-qualified policies using California's eligibility standards, or those sold before 1997, do not have this restriction and can pay benefits even when Medicare pays for part of the cost of care.*

D. Health Underwriting

Long term care insurance is medically underwritten. This means that companies will not insure people who already have health problems that might trigger a need for care. Companies ask health questions on their applications, designed to weed out people with serious health conditions. Some companies refuse to issue coverage until they have reviewed the person's medical records and have verified the answers on the application. Others rely completely on the application itself.

Some companies only ask for medical records after a claim is filed many years later. These companies rely completely on the answers to the medical questions on the application, and do not verify the

information until later. If within two years from the date of the application, the company discovers medical information that is different from the application, the company can rescind the policy, leaving the person with no coverage to pay for their care. After two years, the company cannot do this.

A few companies will offer to sell coverage to people who have certain specified chronic conditions if they are willing to pay higher premiums. However, such companies will not insure someone who already needs care, or who obviously will need it very soon.

One factor that may increase the amount of the premium charged for a LTCI policy is tied to how well a company has handled its medical underwriting. A company that accepts people other companies turn down is much more likely to increase its premiums later. If that same company also charges lower premiums than other companies, consumers should be very cautious and should understand that the amount of the premium could go up dramatically in just a few years.

E. Benefit Eligibility Triggers

Insurance companies need standards to decide when someone is eligible for home and community care benefits. They rarely worry that someone will use their nursing home benefit before they actually need it, because most people do not want to be in a nursing home and resist going to one. On the other hand, people are more likely to want to use a benefit that will pay for home care or assisted living.

In order to control their costs, companies set certain thresholds called "benefit triggers" or "eligibility triggers" that must be met before the company will begin to pay benefits. Insurance companies use measures such as activities of daily living (ADLs) and cognitive impairment to determine when to begin paying benefits. Eligibility for home care benefits usually requires impairment in two or three ADLs from a list of six or seven ADLs, or a cognitive impairment, depending on the year the policy was issued. Policies issued in California after 1999 are required to use no more than two ADLs to qualify for any of the policy benefits.

1. California Eligibility Standard (non-tax-qualified)

These policies must pay benefits for home care when someone is impaired in two out of the seven ADLs listed below:

- Bathing
- Transferring
- Ambulating
- Dressing
- Eating
- Continence
- Toileting

OR

- when the person needs help because of cognitive impairment. (An example would be someone with Alzheimer's disease who needs supervision).

2. Federally Tax-Qualified Policies

These policies cannot pay benefits for home care until a health care practitioner certifies that the person will need care for at least 90 days because he or she cannot perform two out of the six following ADLs without substantial assistance from another person:

- Bathing
- Transferring
- Dressing
- Eating
- Continence
- Toileting

OR

- when the person needs help because of severe cognitive impairment.
- Note: Federally tax qualified policies do not include ambulating as an activity of daily living.

3. Some Differences Between California Standard and Federally Tax Qualified Policies

a. Standard for Impairment in Cognitive Ability

Policies using the California eligibility standard define cognitive impairment as needing supervision or assistance to protect oneself or others because of mental deterioration caused by Alzheimer's disease or other organic diseases. Policies that use the federal eligibility standard use a definition requiring substantial supervision because of severe cognitive impairment. It is not clear if there are significant differences in the way that companies authorize claims under these two standards.

b. Definitions of ADLs

California law requires one set of ADL definitions for policies using the California eligibility standards. A different set of ADL definitions are used in policies using the federal eligibility standards. These definitions describe each ADL. When a person cannot do one of them they have met one of the ADLs necessary to qualify for benefits.

For example, "bathing" in a tax qualified policy means "washing oneself by sponge bath, or in either a tub or shower, including the act of getting into or out of a tub or shower."

However, "bathing" in a policy with California eligibility standards includes "cleaning the body using a tub, shower, or sponge bath, including getting a basin of water, managing

faucets, getting in or out of the tub or shower, and reaching head and body parts for soaping, rinsing and drying."

Although the federal standards may be more difficult to meet, it is not yet clear if there are significant differences in the way that companies authorize claims under these two standards.

The availability of the additional ADL (ambulating) in the California eligibility standards may make it easier for some people to qualify for assisted living or home care benefits. In addition, people with policies using the California eligibility standards do not need to be certified that they will require care for at least 90 days. Such certification is required in tax-qualified policies.

CALIFORNIA ELIGIBILITY STANDARDS: SOME DIFFERENCES FROM TAX QUALIFIED STANDARDS

- *Allows seven instead of six ADLs to be used to qualify for benefits*
- *Expanded ADL definitions*
- *No 90 day certification*
- *Can pay when Medicare pays*

V. Employer And Other Group Policies

Long term care insurance is usually sold through individual policies, but some people may be able to get LTCI through their employer. Although some large employers offer this type of insurance, they rarely pay any of the premiums. Few, if any employers offer non-qualified policies that use the California eligibility standards.

Insurance companies selling LTCI through an employer group will still screen most people for existing medical conditions when they apply for

coverage. Some companies do not conduct health screening of active employees, while others do. Each group handles these issues differently.

Some employers allow the parents, and sometimes the parents-in-law, of their employees and retirees to apply for the group coverage along with active employees and retirees. For instance, the California Public Employees Retirement System (CALPERS) offers long term care coverage to their employees, retirees, and the parents and parents-in-law and even siblings of all their members. However, CALPERS does not pay any part of the premium for LTCI. CALPERS holds an annual open enrollment for their long-term care program. Members of the State Teachers Retirement System are also allowed to apply for the CALPERS benefit, as are some county, city and other types of local public employees.

Other groups, such as an association like AARP, may offer LTCI through their group. In a case like this, the group (AARP for example) owns the master policy and an insurance company sells group certificates of coverage to AARP members. Religious or Faith based organizations and other association groups may also offer long term care coverage to their members.

In some instances, an out of state group may not have to meet the same requirements that insurance companies selling to individuals in California have to meet. This may result in minor differences or substantial differences between an out of state group policy and a policy that meets California's requirements. People considering group coverage should compare it to individual coverage to make sure that they understand the differences, if there are any.

VI. Individual Policies

These policies are sometimes referred to as "private market" policies because anyone can apply for one individually. They are sold one at a time to individuals who do not have to belong to any particular group.

Most individual long term care insurance policies are sold to people between the ages of 68 and 79. Many companies sell to younger people, and a few will sell to people who are over age 80, although they may limit the amount of insurance a very old person can buy. Premiums are substantially higher for people in the older age groups than for people in the younger age groups.

Individuals usually buy a LTCI policy from an agent who comes to the home. The appointment is often made after the individual sends in a response card from an advertisement he or she received in the mail or saw in a magazine. The person is generally offered a choice of policies from the companies that the agent represents. Although some agents only represent one company, most represent several.

Buyers select a company and type of policy based on what the agent shows them. The benefit package they buy depends on the cost of the premium, the choices given to them by the agent and the information they had when making their decision.

VII. The California Partnership For Long Term Care

The "Partnership" is an innovative alliance between the State of California on one hand, and a select number of private insurance companies and CALPERS (discussed earlier in this chapter), on the other hand, that sell Partnership-approved long term care insurance policies. Some of these companies also sell "private market" policies.

These Partnership policies must meet certain requirements established by the California Department of Health Services in addition to other state requirements that all other policies must meet. Furthermore, these policies contain a few features other policies do not have.

Partnership approved policies are available to individuals from specially trained agents. CALPERS members can select a Partnership option from one of the packages offered to them by CALPERS.

A. Asset Protection

Most people will recover or die before using up all of the benefits of any LTCI policy they buy. But a few people will outlive their benefits. A Partnership approved long term care policy has a unique feature. It will pay benefits just as any other LTCI policy would. Then, if the LTCI benefits are used up, and the person still needs long term care, she/he will be allowed to keep the amount of assets equal to the benefits paid by the policy and still qualify for Medi-Cal.

EXAMPLE:

Miss Jones had $43,000 in lifetime savings and bought a Partnership policy covering the same amount of long term care services. Later, Miss Jones needed long term care and the Partnership policy paid a total of $43,000 for her care, using up all of the benefits of the policy.

Miss Jones still needed long term care, but the benefits of the policy were gone, so she applied for Medi-Cal. Because she had used a Partnership policy, she was allowed to keep the entire $43,000 of her assets, not just the $2,000 limit an individual would ordinarily be allowed to keep. Each dollar paid by her Partnership policy protected one dollar of her assets ($43,000 in this case).

*LITTLE **KNOWN FACT:** Without the asset protection of the Partnership program, Miss Jones might have had to spend down her savings before she could qualify for Medi-Cal. The Partnership protection allowed her to keep assets she would otherwise have had to spend for her care.*

In addition, inflation protection is built into every Partnership policy. This means that the amount of protected assets increases each year the policy is kept in force. For instance, $43,000 in benefits will grow by five percent compounded each year. Both the daily benefit

that pays for care, and the total amount of protected assets grow at the same rate. For example, at the end of 13 years, the amount of protected assets from the $43,000 in benefits will have grown to $86,000. Asset protection can apply to cash, investments, savings, home equity or a combination of these assets.

Partnership policies are federally tax qualified, and use the stricter federal eligibility standards for benefits. However, these policies also include a few benefits not required or available in other policies, such as built-in inflation protection and asset protection.

VIII. What Consumers Should Know About Long Term Care Insurance

Consumers in California can select from a wide variety of long term care policies with an almost infinite number of choices. They can choose a federally tax qualified policy, a Partnership policy, or one that meets California standards. They can buy a nursing home only policy, home care only policy, or one that pays for a wide range of different types of care. If a person belongs to a group offering LTCI, she/he can buy either that group coverage, or an individual policy through the marketplace. If not eligible for group coverage, a person can still buy an individual policy in any of these designs.

Long-term care insurance is still a relatively new product. Few people have the information they need to make wise decisions about this type of coverage. Before purchasing a policy, people should think about their future ability to pay premiums for the rest of their life. This type of insurance should generally be purchased with the intention of paying premiums for the balance of a person's lifetime.

Many experts advise consumers not to spend more than seven percent of their annual income for LTCI premiums. This is because insurance companies have the right to raise premiums in the future by any amount they deem necessary. The premium a person pays when they buy a policy may not be the premium he or she will owe five or ten years later. Often,

an older person's income fails to keep up with inflation as they get older. In addition, a woman's income tends to drop when her husband dies. Widows are often faced with some difficult decisions about what they can afford to continue paying when their income is reduced.

A. How Much LTCI To Buy

The amount of insurance a person should buy should be roughly comparable to the assets that they would otherwise have to spend on long term care. Just as it does not make sense to insure a $200,000 house for $1 million, it generally does not make sense to buy LTCI that will pay for ten years of care when a person has only $50,000 in assets. Also, premiums will be higher for each year of benefits a company will pay.

In general, men and women do not need the same amount of LTCI. Women have a higher risk of long nursing home stays. They generally need benefits for more years. Even so, those benefits should be roughly equivalent to the assets they would otherwise have to spend on long term care.

B. Inflation Protection

It also makes very little sense to buy LTC insurance without inflation protection. While California law requires insurance companies to offer inflation protection, it does not require that inflation protection be included in the policy, except for Partnership policies. While this feature does add significant cost to the premium, the alternative can be very grim.

> ***EXAMPLE:***
>
> *Mr. Barrett purchases a daily benefit of $100 without inflation protection. Ten years later, the cost of care has doubled. His benefit will pay less than half of the cost of his care and therefore is worth half as much as when he bought it. Buying a benefit without inflation protection means* ***buying a benefit that decreases each year!***

Few people could be talked into depositing $1,000 a year into a bank that does not pay them interest. Even fewer could be talked into depositing that same amount if they would have to pay the bank interest. Yet this is the effect of paying an annual premium of a $1,000 or more for coverage that does not include inflation protection. It would be better to choose a lower daily benefit, or buy fewer years of coverage, than to risk having no protection against the rising cost of care in later years.

C. Which Benefits To Buy

People need to balance the benefits they can afford with those they have the best chance of using. For instance, a single person living alone without family or friends nearby to help may not be able to use a home care benefit if she/he suffers a disabling stroke that makes living alone impossible. Having an assisted living benefit or a policy that pays in any location that care may be needed would be a better choice for that person.

D. Comparing The Trade-offs

LTC insurance is a series of trade-offs. If people have sufficient income and assets, they need to decide what they can afford to pay and how much insurance they need. If they buy at age 65, the premium will be lower than if they first purchase LTCI at age 75, but at age 65 they will pay premiums for more years over their lifetime. If they wait until they are older, the premium is higher, and they may have developed a health condition that prevents them from getting insurance.

A person with abundant income and assets could plan to pay some or all of their long term care costs himself, or decide to pay for lifetime coverage since she/he can afford it. People who already qualify for Medi-Cal or who would spend all of their assets within a few months do not need long-term care insurance at all, and probably cannot afford the premium.

To make sure that people buying a LTCI policy have adequate income and assets, insurance companies selling LTCI in California are required to use a standard form questionnaire. This form asks the buyer to answer some basic questions designed to help him or her recognize the relationship between his or her own finances and the LTCI coverage applied for. Every person who applies for a LTCI policy should be given a copy of this completed form. The insurance agent keeps another copy of it and sends the original to the LTCI company.

If a consumer does not want to give this financial information to an insurance agent, he or she does not have to fill out the form. However, before issuing the policy, the LTCI company is required to call the consumer to verify that it was the consumer's decision to not provide the information. This form and process helps companies spot sales to individuals who do not have sufficient income or assets to maintain LTCI coverage over many years.

IX. The Counselor's Role

HICAP uses two types of counselors: registered counselors and registered LTC counselors. The HICAP program provides information and face to face counseling. It does not provide advice, specific solutions or recommendations, nor does it recommend insurance companies or products.

Counselors who are not registered LTC counselors usually see clients for the first general discussion about this subject. It is important to help clients understand some of the issues before they consider any financial options or specific policies.

HICAP has a variety of materials that clients may find useful. Clients can take notes and write down questions to ask the HICAP counselor on a future visit. Information and education will make them better consumers and will prepare them to meet with an insurance agent if they decide to buy a policy.

People typically want easy answers to this difficult subject, and there are none. There is no "recipe" and no "one size fits all" solution. This is a complex issue that will require some research on the consumer's part, and a commitment on the counselor's part not to give people specific advice about what they should do.

If HICAP clients want help and advice beyond what makes the counselor comfortable, they should be referred to the HICAP program manager. It is not unusual for clients to feel uncomfortable doing the work that must be done in order to make these complicated decisions. Nor is it unusual for clients to assume that HICAP has predefined answers or solutions. The HICAP program manager should know when a client or a situation makes a HICAP counselor uncomfortable.

Counselors should not be pushed to give advice by challenges like "what would you tell your parents?" or "do you have a LTC policy?" These are personal questions and are not part of counseling. It is okay to tell the client that these are not the types of questions HICAP counselors are allowed to answer and to offer the person to some printed information like the HICAP fact sheets on long term care.

Clients who want more detailed information, specific information about policies, or who need a policy reviewed should be referred to a registered Long Term Care counselor who can help them compare several different policies. These counselors can analyze a policy someone already has or one they are considering, or compare several different LTCI policies.

Clients who want to know about transferring assets and Medi-Cal trusts should be referred to the community legal services program for seniors, elder law attorneys, or the Medi-Cal office. They can also be given whatever handouts each local HICAP program uses.

Clients who are considering a life insurance policy or annuity with long term care benefits should see a professional financial planner who can help them with their estate planning goals. HICAP counselors should not give advice about these products, and these products should not be purchased without professional advice.

Clients who want to know about tax qualified policies and how it relates to their own financial circumstances should be referred to their accountant or financial advisor. Counselors who are also working in a tax assistance program must refrain from advising people about tax issues while working as a HICAP counselor.

When in doubt, a HICAP counselor should always consult the HICAP program manager. And it is always okay to tell a client, "I don't know, but I will ask my program manager and call you."

[This Page Intentionally Blank}

Chapter 12

Medicare Modernization Act, Part D Prescription Drug Benefits

I. Introduction

A. Background

Medicare has not traditionally covered prescription drugs, except when administered in a hospital setting (under Part A) or certain outpatient drugs that cannot be self-administered (under Part B). In addition, certain Medicare Advantage plans have provided limited prescription coverage for their members.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (also known as the "Medicare Modernization Act" or "MMA") imposes the most sweeping changes to the Medicare program since its inception, including the addition of a prescription drug benefit through a new "Part D." While filling a major gap in Medicare's coverage by adding a prescription drug benefit to the program, the MMA significantly increases the role that private insurance will play in providing health care for Medicare beneficiaries.

B. Overview of the MMA

1. Part D – Prescription Drug Benefit (2006)

Under the Medicare Modernization Act, Part D will begin offering broader prescription drug coverage to Medicare beneficiaries in 2006. The privately administered stand alone prescription drug plans (PDPs) and Medicare Advantage plans that offer prescription benefits (MA-PDs) will charge monthly premiums,

require an annual deductible, and impose cost-sharing thresholds. There will be significant gaps in Part D coverage and beneficiaries will be restricted to formularies developed by individual Part D plans.

Like the rest of the Medicare program, Part D plans are monitored by a federal agency – the Centers for Medicare and Medicaid Services (CMS). CMS reviews and approves Part D benefits offered by individual companies and is responsible for ensuring that Part D plans follow certain guidelines.

Companies that offer Part D plans have a certain amount of flexibility in designing formularies and cost-sharing structures. This variation in benefit structures along with complicated cost-sharing calculations can make it hard for beneficiaries to understand the Part D benefit and to compare plans in order to make informed choices about which plan might meet their individual needs.

2. Other Changes to Medicare

The impact of the Medicare Modernization Act and the Part D drug benefit affects other aspects of the Medicare program that are discussed throughout this manual. These changes include:

- New preventive benefits and increases in the Part B premium and deductible (discussed in Chapter IV);
- Changes to the Medicare managed care program (now called "Medicare Advantage"), including "lock-in rules" and new types of plans that may be offered (discussed in Chapter V);
- A Part D appeals (or "exceptions") process as well as changes to existing fee-for-service and managed care appeals (discussed in Chapter VI);
- New rules for Medicare Supplemental Insurance policies (Medigaps) that offer prescription drug coverage (H, I and J)

and two new types of plans (K and L) (discussed in Chapter Seven);

- Choices that both retiree plans that offer prescription drug coverage and their beneficiaries must make in relation to Part D (discussed in Chapter Eight); and
- How certain low income individuals will be impacted by Part D, including the availability of financial assistance with Part D drug costs (low-income subsidy) and changes to drug coverage for individuals who are eligible for both Medicare and Medi-Cal (dual eligibles) (discussed in Chapter Nine).

3. Drug Discount Card (Through 2005)

The MMA also created a temporary Medicare Prescription Drug Discount Card (DDC) and Transitional Assistance (TA) Program, which first became available in the spring of 2004. This program will expire when the prescription drug benefit takes effect in 2006. Under this temporary program, Medicare beneficiaries who do not already have prescription drug coverage through Medi-Cal may choose to enroll in Medicare-approved private prescription drug management plans that offer enrollees discounts on certain drugs included in their formularies. In addition, certain beneficiaries with low income could qualify for the Transitional Assistance (TA) program, which provided up to $600 a year in credit to be used towards drug expenses.

While the Discount Drug Card program is designed to last through 2005, beneficiaries can still use their cards (and any left over Transitional Assistance funds) until May 15, 2006 (the end of the Part D initial enrollment period) or until they enroll in a Part D plan, whichever occurs sooner.

C. Scope Of This Chapter

This chapter will discuss the new Part D prescription drug program, including: eligibility, enrollment and disenrollment; premiums, penalties and creditable coverage; and benefits, including benefit structures, out-of-pocket costs and covered drugs.

II. Eligibility, Enrollment And Disenrollment

A. Eligibility

Medicare beneficiaries do not need to be enrolled in both Parts A and B in order to be eligible to enroll in the Part D benefit, unless they want to join a Medicare Advantage plan.

Persons entitled to Medicare benefits under Part A and/or Medicare Part B may enroll in Part D as follows:

- A fee-for-service Medicare beneficiary may enroll in a stand-alone prescription drug plan (PDP);
- A member of a Medicare Advantage plan that offers prescription drug coverage (MA-PD) may obtain coverage through that plan but not through a stand-alone PDP;
- A member of a Medicare Advantage private fee-for-service plan that does not provide Part D (or equivalent) prescription drug coverage is eligible to enroll in a stand-alone PDP;
- A participant in a Medical Savings Account may enroll in a PDP.

NOTE: *See Chapter Five for explanations of private fee for service plans and medical savings accounts.*

B. Enrollment

Similar to Medicare Advantage rules taking effect in 2006 (see Chapter V,) beneficiaries' ability to enroll, switch or disenroll from their Part D plans will be restricted to certain times of the year. Outside of these enrollment periods, beneficiaries will be "locked-in"

to their Part D plans (both PDPs and MA-PDs). This means that they will be unable to change plans on a monthly basis.

During the implementation of Part D in late 2005 and early 2006, these enrollment periods are more flexible than in later years, beginning in late 2006 (for the 2007 enrollment year). People with both Medicare and Medi-Cal (dual eligibles) and individuals who are in nursing homes have more flexibility.

1. How to Enroll in a Part D Plan

In order to enroll in a Part D plan, a beneficiary must fill out a standardized enrollment form and submit it to the plan (either a PDP or MA-PD). Some Part D plans may choose to allow individuals to fill out and submit enrollment forms on the Internet. Internet enrollment may be available through the Medicare Web site (www.medicare.gov) which will also provide comparative information on plans beginning in October 2005. Individuals will not be able to enroll in Part D plans over the phone.

2. Initial Enrollment Period (IEP)

The Initial enrollment period (IEP) is the period during which an individual is first eligible to enroll in a Part D plan. The Part D IEP for those who are presently enrolled in Medicare or who will be enrolled on or prior to January 31, 2005, is from November 15, 2005, through May 15, 2006 (6 months). There is a short transition period at the end of which, the Part D IEP will mirror the Initial Enrollment Period for Medicare Part B. For those individuals who become eligible in February 2006, the IEP is from November 15, 2005, through May 31, 2005 (six and a half months). The individual who becomes eligible for Part D in March or thereafter has the same seven month IEP as Part B.

EXAMPLE:

Mrs. Jones is turning 65 on June 25, 2006. She is eligible for Medicare on June 1, 2006. Mrs. Jones' Initial Enrollment Period is the seven month period (March, April, May, June, July, August, and September) beginning in March 2006 and through the month of September 2006. Since Mrs. Jones' birthday falls in June, her Medicare prescription drug coverage cannot begin any earlier than June 1.

3. Annual Election Period (AEP)

The annual coordinated election period (AEP) is the time during which an individual can make a Part D enrollment election for the following calendar year. For 2006, the AEP is the same as the initial enrollment period (IEP): November 15, 2005, through May 15, 2006. Beginning in the fall of 2006 and in subsequent years, the AEP is from November 15 through December 31 of a given year, with the Part D plan becoming effective the following January 1.

4. Special Enrollment Periods (SEPs)

The MMA allows for individuals to enroll in or disenroll from Part D plans outside of the IEP or AEP during special enrollment periods (SEPs) triggered by certain designated events. SEPs are available in various scenarios, including when:

- an individual involuntarily loses creditable prescription drug coverage or such coverage is involuntarily reduced so that it is no longer considered creditable (see discussion of creditable coverage below);
- an individual was not adequately informed about the status of creditable coverage;

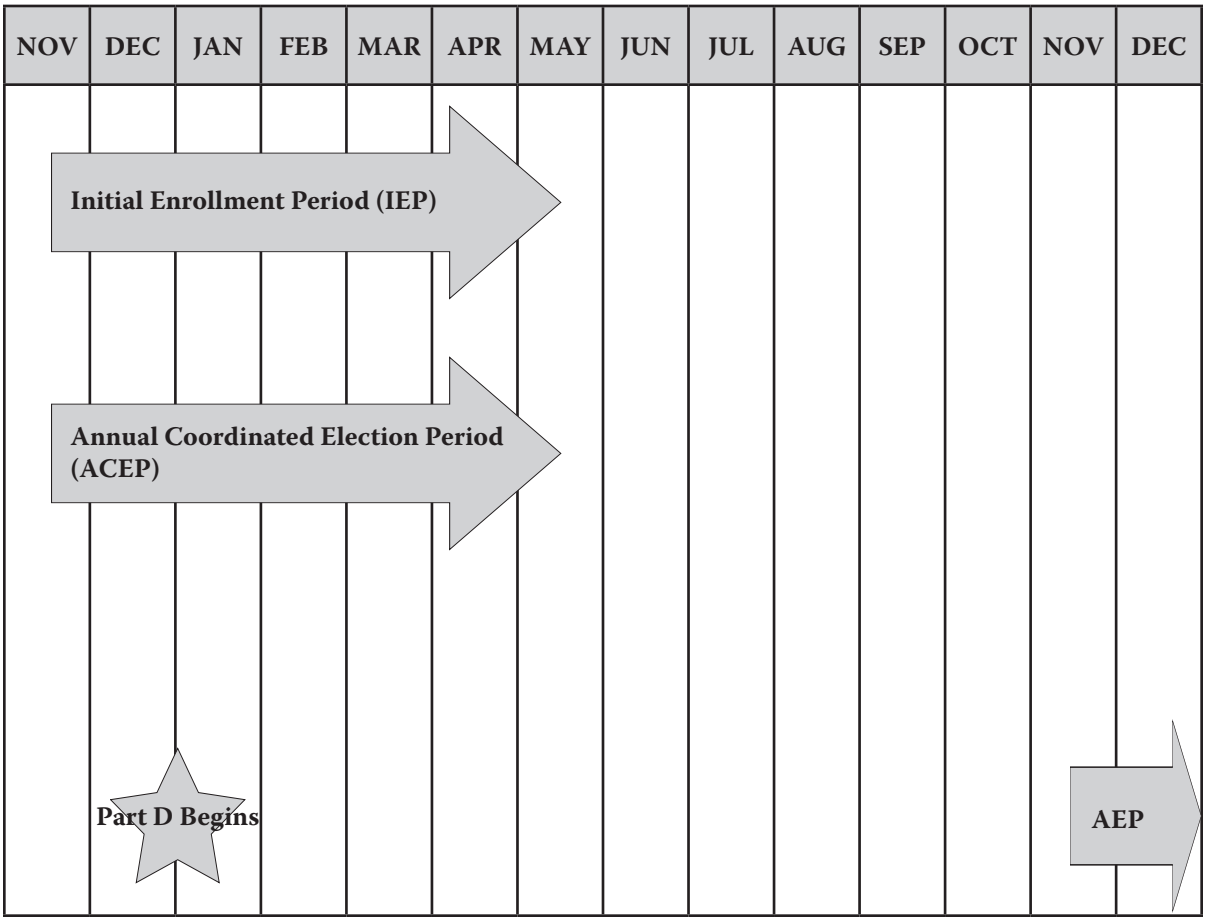
- unintentional, inadvertent, or erroneous enrollment/non-enrollment occurs due to the action or inaction of a federal employee;
- an individual disenrolls from an MA-PD plan during the first year of MA plan eligibility;
- a PDP contract is terminated or no longer offered in the area in which an individual resides;
- an individual no longer resides in a PDP's service area;
- an individual experiences a substantial breach of contract by their plan; and
- other "exceptional circumstances" that CMS may provide including for individuals in long-term care facilities, individuals enrolled in employer plans, and individuals eligible for the Part D low-income subsidy whose enrollment will be facilitated. CMS may establish SEPs on a case-by-case basis, where warranted by an immediate exceptional circumstance, such as an individual with a life-threatening condition or illness.

Individuals who have both Medicare and Medi-Cal (dual eligibles) have an ongoing SEP, meaning that they are not locked-in to their Part D plans and can change plans on a monthly basis.

Because many beneficiaries will be locked-in to their Part D plans during the course of a calendar year, Special Enrollment Periods can be a critical advocacy tool to assist those non-dual eligibles who need to either get into a Part D plan to access prescription drug coverage or get out of an existing plan because their needs are not being met.

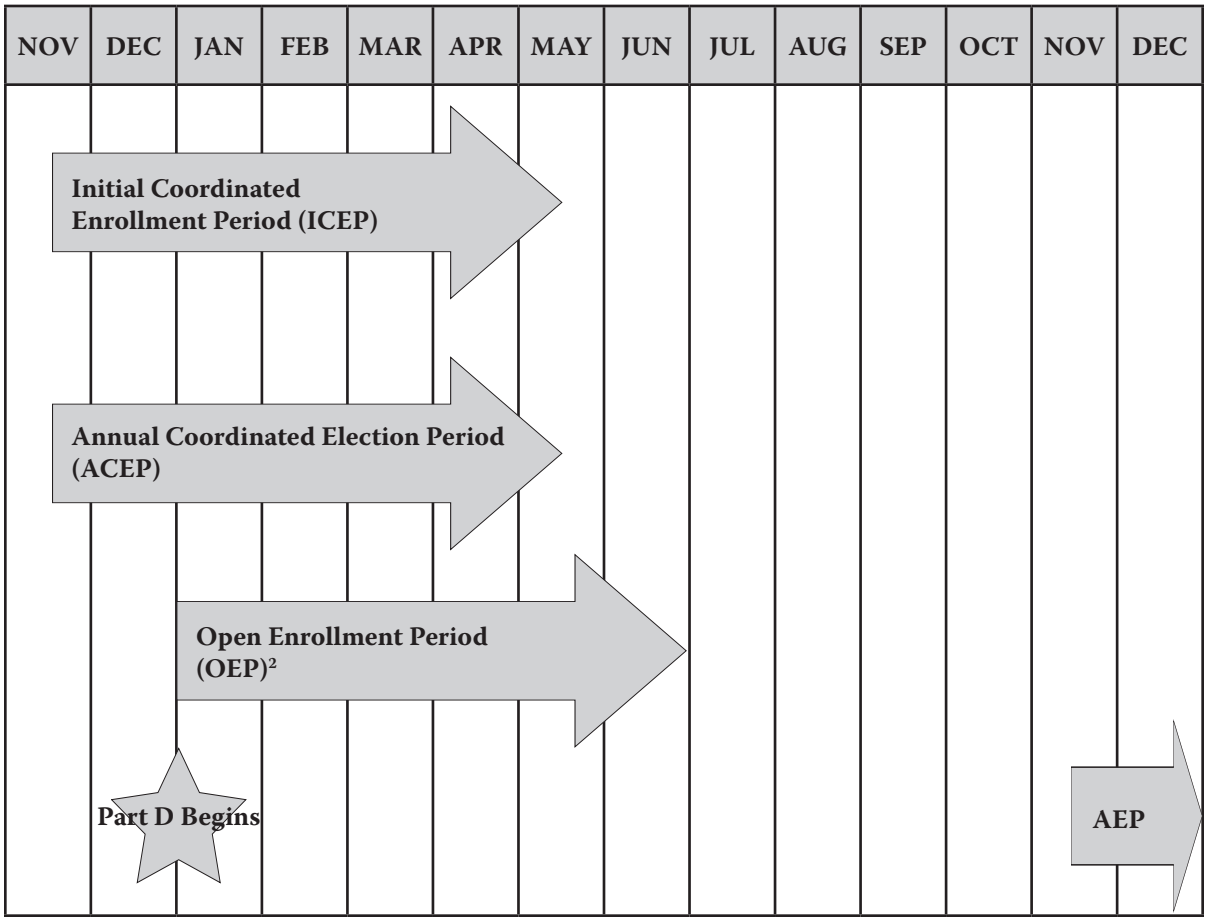
Medicare Advantage enrollees have similar SEP rights and there is also an SEP relating to enrollment in Medicare Part B for beneficiaries who have primary insurance coverage through an employer group health plan, as discussed in Chapter V.

2006 PDP Enrollment Periods[1]



1. Does not reflect SEPs

2006 MA-PDP Enrollment Periods[1]



1. Does not reflect SEPs.
2. Open and limited to same type of drug coverage.

C. Disenrollment

1. Voluntary Disenrollment (By Enrollee)

There are restrictions on when a beneficiary may enroll in a Part D plan, switch plans and disenroll from a Part D plan (including MA-PDs, as discussed in Chapter V). If someone wants to get out of (or disenroll) from a Part D plan, she/he will generally be restricted to the enrollment periods described above.

- in order to disenroll from a Part D plan, an individual may:
- enroll in another Part D plan; or
- file a disenrollment request with the plan.

2. Involuntary Disenrollment (By Plan)

As a general rule, a Part D plan may not involuntarily disenroll an individual and cannot request or encourage that person to disenroll. However, there are certain instances in which a Part D plan has the option of disenrolling an individual or is required to do so.

Because beneficiaries will have limited opportunities to enroll in Part D plans during the course of a calendar year, involuntary disenrollment by a PDP can have potentially serious consequences for a beneficiary. That person could lose all prescription drug coverage without an opportunity to obtain any coverage from a PDP until the following calendar year.

a. Optional Disenrollment by PDP

A Part D plan may choose to disenroll an enrollee in the following two situations:

- Any monthly premium is not paid on a timely basis. The plan must demonstrate reasonable collection efforts and compliance with notice requirements; the plan can refuse re-enrollment until all past premiums are paid; or

- The individual has engaged in "disruptive behavior" defined as behavior that "substantially impairs the plan's ability to arrange or provide for services to the individual or other plan members. An individual cannot be considered disruptive if the behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment" (see Title 42, Code of Federal Regulations, §423.44). A PDP sponsor must make specified efforts to resolve the problem and may only disenroll the individual after CMS review and approval.

b. Required Disenrollment by PDP

A Part D plan must disenroll an individual if:

- the individual no longer resides in the PDP's service area;
- the individual loses eligibility for Part D;
- the individual dies;
- the PDP contract is terminated by CMS or by a PDP or through mutual consent; or
- the individual materially misrepresents information to the PDP that the individual has or expects to receive reimbursement for third-party coverage.

III. Premiums, Penalties And Creditable Coverage

Although enrollment in the new Part D drug benefit is voluntary, individuals who decline the coverage when first eligible will have to pay a premium penalty if they later decide to enroll unless they have alternate creditable prescription drug coverage (defined below).

A. Premiums For Part D Plans

Part D plans are allowed to charge monthly premiums based on bids approved by CMS. The monthly premium for a standard Part D plan

is estimated to be $37 in 2006. Beneficiaries can pay the monthly premium one of several ways:

- directly to the PDP or MA-PD;
- have the amount withheld from his or her Social Security payment (similar to the Part B premium); or
- make payment through an electronic funds transfer mechanism.

B. Late Enrollment Penalties

The late enrollment penalty applies to eligible individuals who do not enroll in Part D by the last day of their Initial Enrollment Period. The penalty also applies to an individual who has lost or failed to maintain other creditable coverage for more than a continuous period of 63 days prior to enrollment in Part D. The penalty in either case is at least one percent of the base (or standard plan) premium for each uncovered month and it applies as long as the individual is enrolled in Part D.

EXAMPLE:

Mrs. Sanchez, 67, decides not to enroll in a Medicare prescription drug plan during her Initial Enrollment Period in the fall of 2005. She currently has no other prescription drug coverage.

Mrs. Sanchez later decides to enroll in a Medicare prescription drug plan during the next Annual Coordinated Election Period (AEP) and her enrollment in the plan is effective January 1, 2007.

Because Mrs. Sanchez is without drug coverage that is at least as good as Medicare prescription drug coverage, from the end of her Initial Enrollment Period (May 15, 2006) until January 1, 2007, she will pay a higher premium. Because she had a period exceeding 63 consecutive days, her higher premium is based on seven full months (June, July, August, September, October, November, December). She will pay one percent for each uncovered month or a total of seven percent of the base premium ($37 in 2006), as long as she is enrolled in Part D.

C. Creditable Coverage

1. Definition of "Creditable Coverage"

An individual is considered to have "creditable prescription drug coverage" if their existing coverage is considered to be at least as good as the standard Part D benefit (or "actuarially equivalent"). Certain types of coverage may be considered creditable including:

- group health plan coverage including retiree coverage;
- individual insurance coverage;
- medicare supplemental coverage (Medigap – see Chapter Seven for further discussion re: Part D and Medigaps);

- military coverage (V.A. Benefits and TRICARE for Life); and
- other coverage that CMS determines is appropriate.

2. Notice to Beneficiaries

Entities offering creditable prescription drug coverage (including private and government employers) must provide notice to Part D eligible enrollees concerning the status of their coverage (i.e., whether the coverage is considered creditable under Part D rules).

If an entity offers coverage that is not creditable, the entity must disclose to the enrollee the fact that the actuarial value does not meet Part D requirements, there are limited periods for PDP enrollment, and the possibility of a late enrollment penalty.

Notice to Part D eligible individuals must be provided at the following times:

- prior to an individual's initial enrollment period (IEP) for Part D;
- prior to the effective date of enrollment in the Part D plan and on any change that affects whether the coverage is creditable;
- prior to the commencement of the annual coordinated election period (AEP); and
- upon request of the individual.

In addition, these entities must report the creditable status of coverage they offer to CMS.

NOTE: *If an individual is able to prove to CMS that he or she was not adequately informed that his or her prescription drug coverage was not creditable, the individual may apply to CMS to have the coverage treated as creditable for purposes of the late enrollment penalty. Also, this scenario might entitle a beneficiary to a special enrollment period (SEP) to join a Part D plan outside of the regular enrollment periods.*

IV. Benefits Under Part D

The Medicare Modernization Act created a new prescription drug benefit (Part D), which is offered through private companies beginning January 2006. These private companies -- stand alone prescription drug plans (PDPs) and Medicare Advantage plans that offer prescription benefits (MA-PDs) -- will charge monthly premiums, require an annual deductible, and impose cost-sharing thresholds. There are significant gaps in Part D coverage, however, and beneficiaries will be restricted to formularies developed by individual Part D plans. Further, beneficiaries are responsible for the full cost of any drugs not covered by an individual Part D plan's formulary, and such expenses do not count towards any Part D cost-sharing thresholds.

Part D plans have a certain amount of flexibility in designing formularies and cost-sharing structures. As mentioned at the outset of this chapter, this variation of benefit structures along with complicated cost-sharing calculations will make it hard for beneficiaries to understand the Part D benefit and compare plans to make informed choices about which plans might meet their individual needs.

A. Benefit Structures

Private plans that choose to offer the Part D drug benefit have flexibility in designing their benefit packages as long as the benefits and beneficiary cost-sharing are considered to be at least as good as the standard benefit. Part D plans can offer:

1) Standard prescription drug coverage;

2) Alternative prescription drug coverage (that has equal or better benefits than the standard coverage but different cost-sharing amounts); or

3) Enhanced alternative prescription drug coverage, which offers more coverage than the "standard" plans.

In addition to these structures, Part D plans will likely have tiered formularies (lists of preferred and non-preferred drugs) and cost-

sharing rules, as well as preferred and non-preferred pharmacies that will alter the cost sharing that beneficiaries pay (and make it more difficult for them to compare and understand plans).

The Medicare Modernization Act also allows for Part D plans to use cost or utilization management tools. Such utilization tools can include prior authorization requirements, step therapy (meaning payment is restricted unless certain other drugs are tried first) and therapeutic substitution (where a beneficiary is switched to a preferred drug on the formulary).

1. Standard (or Basic) Prescription Drug Coverage

Standard prescription drug coverage is defined as coverage that offers "covered Part D drugs" and, in addition to charging a monthly premium, is structured as follows (also see chart below):

Annual Deductible – In 2006, the deductible is $250.

Initial Coverage Limit – After a beneficiary satisfies the deductible, the Part D plan covers 75 percent of the next $2,000 in drug costs until total drug expenses (both out of pocket and those paid by the plan) reach $2,250 in 2006.

Gap in Coverage – After a beneficiary reaches the initial coverage limit, the beneficiary is responsible for all drug costs until the annual out-of-pocket threshold is met. This gap in coverage is commonly referred to as the "doughnut hole" and is $2,850 in 2006.

Annual Out-of-Pocket Threshold – Once a beneficiary's total drug expenses (both out of pocket and those paid by the plan) reach $5,100 in 2006, Part D coverage will begin again; at that point, beneficiaries are responsible for either co-payments of $2 for generic (or preferred) drugs or $5 for any other drug, or a five percent coinsurance, whichever is greater. The annual out-of-pocket threshold is also known as the "stop-loss" or "catastrophic" threshold.

The deductible and cost-sharing thresholds (in addition to monthly premiums) will increase annually based on a formula defined by the law. This, of course, means that beneficiaries will pay more out of pocket in subsequent years.

Standard Part D Coverage for 2006

Coverage	Drug Costs	Part D Plan Pays	Beneficiary Pays
Annual Deductible	$0 – $250	$0	$250
Initial Coverage	$251 – $2,250	75% ($1,500)	25% ($500)
No Coverage (Doughnut Hole)	$2,251 – $5,100	$0	100% ($2,850)
Out-of-Pocket Threshold	Over $5,100	95% of remaining costs	Up to 5% of remaining costs

NOTE: *Beneficiary expenses for drugs not covered by an individual Part D plan's formulary do not count against the threshold amounts.*

2. Alternative Prescription Drug Coverage

A PDP or MA-PD plan may provide a benefit design different from the standard benefit as long as it is equal (actuarially equivalent) to the standard benefit and it is approved by CMS. The alternative coverage must provide the same protection against high out-of-pocket expenditures as the standard benefit provides and may not exceed the annual deductible amount. This means that as long as a plan does not charge more than the standard annual deductible ($250 in 2006) and that the out of pocket threshold is not greater than the standard plan ($5,100 in total costs in 2006) the plan can alter the cost-sharing amounts

discussed above (including making the deductible and threshold lower than the standard amount).

3. Enhanced Alternative Prescription Drug Coverage

In addition to an alternative prescription drug benefit that is actuarially equivalent to the standard drug benefit, a Part D plan may offer an enhanced alternative benefit that is better than the standard benefit, meaning it offers greater coverage and/or lesser cost-sharing. Such a plan must meet the guidelines of an alternative drug coverage plan and must offer additional benefits, which can include:

- coverage of drugs that are specifically excluded as Part D drugs;
- reduction of the annual deductible;
- reduction of cost-sharing in the initial coverage limit or annual out-of-pocket threshold;
- increase in the initial coverage limit; or
- any combination of the above.

These plans will most likely charge a higher premium for the enhanced coverage.

B. Incurred (Out Of Pocket) Costs

Because coverage under Part D is structured around cost-sharing thresholds, it is crucial for Part D plan providers (and beneficiaries) to determine actual costs that a beneficiary has incurred and whether those costs count towards the Part D plan cost-sharing thresholds. For example, a Part D plan provider will need to know when a beneficiary has spent enough in out-of-pocket expenses to reach the annual (or catastrophic) threshold. Not all costs incurred by a beneficiary, however, are counted towards these cost-sharing thresholds.

1. Payments Counted as Incurred Costs

Incurred costs that count toward the Part D cost-sharing thresholds are referred to as "true out of pocket expenses" or "TrOOP." Incurred costs only include costs incurred for covered Part D drugs (see below), for the annual deductible, cost sharing, and amounts a beneficiary pays while in the "doughnut hole."

Costs are treated as incurred only if they are paid by:

- the eligible individual;
- another person on behalf of the eligible individual; or
- through the low income subsidy (LIS).

If, however, the beneficiary is reimbursed for such costs through insurance, a group health plan, or other third party payment arrangements, such costs do not count toward his/her incurred costs. Further, if a beneficiary does not disclose to the Part D plan that another organization such as an insurance plan is paying for some of his/her drugs, the Part D plan may involuntarily disenroll the beneficiary.

For purposes of allowing payments made on behalf of a Part D enrollee to count towards their true out of pocket costs (TrOOP), CMS has interpreted "person" to include not-for-profit corporations, trusts and estates, and certain other entities, including "charities." This could include a drug manufacturer's patient assistance program.

CMS may track beneficiary incurred costs and can update Part D plans with this information; this will most likely be performed by a CMS contractor. Part D plans can also periodically survey enrollees concerning incurred expenses.

2. Costs Not Counted as Incurred Costs

Incurred costs (or TrOOP) do not include any costs incurred for covered Part D drugs that are not included in a plan's formulary.

In other words, if a beneficiary needs a prescription drug that is not covered by his or her particular Part D plan, that beneficiary must pay out of pocket for that drug (or appeal to have the drug covered), and those expenses do not count towards any out-of-pocket thresholds. Also, drugs purchased outside of the United States, such as from Canada, do NOT count as incurred costs, nor do the monthly plan premiums.

Understanding this limitation is crucial to understanding the limitations of Part D coverage in general; the fact that costs of drugs not on a given plan's formulary do not count towards any Part D cost-sharing thresholds will undoubtedly cause confusion among enrollees.

EXAMPLE:

Mr. Harrison has a Medicare Part D plan and has already paid the $250 deductible. He then purchases a drug on his plan's formulary that costs $100. The PDP will pay $75 and Mr. Harrison is responsible for a $25 co-payment. The $25 will be counted toward his out-of-pocket threshold. (The $250 deductible paid earlier would count also).

After Mr. Harrison accumulates $2,250 in covered drug costs, he enters the gap in coverage ("donut hole"). He then purchases a brand name drug NOT on his plan's formulary. The cost of this drug will not count towards his out-of-pocket threshold (the donut hole).

C. Covered Drugs

The Medicare Modernization Act defines the scope of drugs that may be covered under Part D. Individual Part D plans, however, can create formularies that do not cover all Part D drugs, as long as the plans meet CMS guidelines and approval. CMS will not establish a standard, mandatory formulary.

CMS does mandate that a formulary include at least two drugs within each therapeutic category and class of covered Part D drugs, although not necessarily all the drugs within such categories and classes, subject to certain exceptions. In general, a "category" of drugs broadly treats a particular disease, and may have "classes" of drugs within that category that are divided based upon their composition or ingredients.

1. Part D Drugs

a. Drugs Covered Under Part D

The MMA generally defines "covered Part D drug" as a drug that may be dispensed only by prescription including both brand name and generic, a biological product (such as a vaccine), or insulin and medical supplies associated with the injection of insulin and vaccines.

b. Drugs Not Covered Under Part D

Certain drugs are excluded under Part D. They include the following:

- Drugs for:
  - ◊ Anorexia, weight loss, or weight gain
  - ◊ Fertility
  - ◊ Cosmetic purposes or hair growth
  - ◊ Symptomatic relief of cough and colds
- Prescription vitamins and mineral products
  - ◊ Except prenatal vitamins and fluoride preparations
- Non-prescription drugs (over the counter)
- Barbiturates (including certain drugs used to treat epilepsy)
- Benzodiazepines (including certain drugs used to treat anxiety and insomnia)

Part D coverage also excludes drugs that are covered, or could be covered, under Medicare Parts A or B. Drugs that are currently covered under Parts A and B will continue to be covered under these Parts. This exclusion is significant for beneficiaries who are enrolled in Part D plans but may not have Part A or B of Medicare. For example, a Medicare beneficiary with Part A (and not Part B) who is enrolled in a Part D plan will have no coverage for any current Part B drugs, such as oral anti-cancer medications; the Part D plan will not cover this drug because it "could have been covered" under Part B.

2. Formularies

Part D plans can restrict enrollees' access to Part D drugs in various ways, including the use of a formulary (a list of covered drugs). Formularies can be "tiered," meaning that an enrollee pays less for "preferred" drugs than "non-preferred" drugs.

If a Part D plan chooses to use restrictions such as formularies, it must meet certain requirements, including:

- establishing a pharmacy and therapeutic (P & T) committee to develop and review the plan's formulary;
- a prohibition on changing the therapeutic categories and classes in a formulary other than at the beginning of each plan year; and
- restrictions on changing their formularies without giving certain notice to beneficiaries.

a. Notice of Change in Formulary

A Part D plan must provide direct written notice to enrollees at least 60 days before the date the formulary change becomes effective. Alternatively, at the time an enrollee requests a refill of the Part D drug, the plan must provide the person with a 60-day supply of the Part D drug as well as written notice of the formulary change.

b. Removal of Covered Drug from Formulary

A Part D plan is prohibited from removing a covered Part D drug from its formulary or making a change in its cost-tiering structure between the beginning of the annual coordinated election period (AEP) and 60 days after the beginning of the contract year.

c. Drugs Included in Formulary

A formulary must include at least two drugs within each therapeutic category and class of covered Part D drugs, although not necessarily all drugs within such categories and classes, subject to certain exceptions. (A "category" of drugs broadly treats a particular disease, and may have "classes" of drugs within that category that are divided based upon their composition or ingredients).

Part D plans must also design their benefits (including which drugs they cover and what cost management tools they use) in such a way so that people who use more drugs are not discouraged from enrolling in that plan. In other words, Part D plans must follow "non-discrimination" rules that are enforced by CMS.

d. Obtaining Coverage for Drugs Not Included in Formulary

There is an "exceptions process" through which beneficiaries can appeal for either coverage of Part D drugs that are not on an individual plan's formulary or for a reduction in cost-sharing for a covered drug (see section V below for a brief description and Chapter Six for more details).

CMS requires a Part D plan to provide for a "transition process" for new enrollees who are prescribed Part D drugs that are not on their plan's formulary. This transition process must meet requirements consistent with written policy guidelines and other CMS instructions.

3. Access to Negotiated Prices

Part D plans must provide beneficiaries with access to "negotiated prices" for covered Part D drugs – this means that plans must pass on certain discounts they get from drug manufacturers – even when the plan is not paying for a beneficiary's drugs (for example, when the beneficiary is in the "doughnut hole").

4. Waiver of Cost-Sharing by Pharmacies

If a pharmacy determines that a beneficiary is financially needy, or is unable to collect Part D cost sharing from a beneficiary after reasonable efforts, pharmacies are permitted to waive or reduce Part D cost-sharing amounts as long as they don't do so routinely and don't advertise that they do so.

In addition, a pharmacy may waive or reduce a beneficiary's Part D cost sharing without regard to these standards for beneficiaries enrolled in the low-income subsidy (see section VI below and Chapter Nine) as long as they don't advertise this. Any waiver or reduction in cost sharing still counts towards a beneficiary's out of pocket expenses.

V. Part D Appeals ("Exceptions") Process

Individuals enrolled in a Part D plan may find that they need prescription drugs that are not covered by their plans, or that a covered drug is in a high cost-sharing tier (meaning that it costs more than other covered drugs). In these situations, enrollees can request an "exception" to their plans' rules through an appeals process modeled after the Medicare managed care (Medicare Advantage) appeals process. This appeals (or "exceptions") process is discussed further in Chapter VI.

VI. Financial Assistance With Part D Costs: Low-Income Subsidy

The Medicare Modernization Act (MMA) provides for financial assistance with Part D premiums and cost sharing for certain low-income Medicare beneficiaries. This financial assistance is called the low-income subsidy (LIS). There are different levels of benefits under the subsidy, depending on an individual's income and assets. Benefits include elimination or reduction of the premium, reduction of cost sharing, and no gap in coverage (or doughnut hole). Medicare beneficiaries who are also covered by Medi-Cal will be automatically enrolled in the low-income subsidy, as will beneficiaries enrolled in a Medicare Savings Program (QMB, SLMB, QI-1).

Other low-income individuals who are not enrolled in Medi-Cal or a Medicare Savings Program may still be eligible for the low-income subsidy, but must actively apply for it. For more information on the low-income subsidy, see Chapter Nine.

VII. Changes To The Medicare Advantage Program

Under the Medicare Modernization Act (MMA), Part C of Medicare is renamed "Medicare Advantage" (MA) and replaces the "Medicare+Choice" program. Medicare Advantage plans will offer prescription drug coverage through Medicare Part D beginning in January 2006, as an alternative to stand-alone prescription drug plans for Medicare fee-for-service beneficiaries. These plans will be known as "Medicare Advantage—Prescription Drug" plans, or "MA-PDs." In addition, there may be new types of Medicare Advantage plans, including Regional Preferred Provider Organizations (PPOs) that can be offered on a statewide basis.

In addition to the availability of a prescription drug benefit through Medicare Part D, there will be changes for MA enrollees concerning their ability to enroll, switch, and disenroll from MA plans. Starting in

2006, beneficiaries are "locked-in" to their MA plans for the course of a calendar year. These changes are discussed in detail in Chapter V.

VIII. New Medicare Supplemental Insurance Policy (Medigap) Rules

The MMA imposes significant changes for Medicare beneficiaries who have Medigaps that offer some type of prescription drug coverage (either a standardized plan H, I, or J, or a pre-standardized Medigap offering prescription coverage). For example, Medigap plans H, I, and J can no longer be sold after January 1, 2006. Individuals with these Medigap plans have important decisions to make at the end of 2005 concerning what type of prescription coverage they want. In addition, the MMA allows for two new types of plans (K and L). These changes are discussed in detail in Chapter Seven.

IX. Impact On Individuals Dually Eligible For Medicare & Medical

Individuals who have both Medicare and Medi-Cal ("dual eligibles") also face significant changes to their prescription drug coverage. The Medicare Modernization Act (MMA) eliminates prescription drug coverage through Medi-Cal for this group, and requires them to obtain Medicare Part D prescription drug coverage. As of January 1, 2006, Medi-Cal no longer covers most prescription drugs for dual eligibles. (Medi-Cal may continue to cover the drugs that are excluded under Part D). Dual eligibles will be automatically enrolled in both the low-income subsidy (LIS) and into individual Part D plans. These and other changes facing dual eligibles are discussed in Chapter Nine.

Acronyms Used Throughout This Handbook

A & D FPL – Aged & Disabled Federal Poverty Level Program (Medi-Cal)

ABN – Advanced Beneficiary Notice

AEP – Annual Election Period

AIC – Amount in Controversy (for ALJ and federal court appeals)

ALJ – Administrative Law Judge (for Medicare appeals)

ALS – Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)

BBA – Balanced Budget Act

BIPA – Benefits Improvement and Protection Act

CMS – Centers for Medicare and Medicaid Services

COBRA – Consolidated Omnibus Budget Reconciliation Act – extended employer-based coverage following loss of employment

CORF – Comprehensive Outpatient Rehabilitation Facility

DHHS – Department of Health and Human Services (federal)

DHS – Department of Health Services (state – Medi-Cal agency)

DME – Durable Medical Equipment

DPSS – Department of Public Social Services (county welfare office)

EGHP – Employer Group Health Plan (age 65+, at least 20 employees)

ESRD – End Stage Renal Disease

FFS – Fee-for-Service (original Medicare)

HHA – Home Health Agency

HINN – Hospital Issued Notice of Non-Coverage

HHRG – Home Health Resource Group

HMO – Health Maintenance Organization

ICEP – Initial Coverage Election Period (for MA plans)

IEP – Initial Enrollment Period (for Parts A, B and D)

IHSS – In-Home Supportive Services program (Medi-Cal program)

IRE – Independent Review Entity (Maximus/CHDR)

LGHP – Large Group Health Plan (under 65, at least 100 employees)

LIS – Low Income Subsidy (Part D)

LTCI – Long Term Care Insurance

MA – Medicare Advantage (including Medicare managed care)

MAC – Medicare Appeals Council

MA-PD – Medicare Advantage – Prescription Drug Plan (includes Part D coverage)

MedPARD – Medicare Directory of Participating Physicians

MMA – Medicare Modernization Act of 2003

MSA – Medical Savings Accounts (type of Medicare Advantage plan)

MSN – Medicare Summary Notice

MSP – Medicare Savings Program (QMB, SLMB, QI, QDWI)

MSP – Medicare Secondary Payer

NHIC – National Heritage Insurance Company

NODMAR – Notice of Discharge and Medicare Appeal Rights

OASIS – Outcome and Assessment Information Set

OEP – Open Enrollment Period

PDP – Stand alone prescription drug plan (Part D)

PFFS – Private Fee-for-Service plan (type of Medicare Advantage plan)

POS – Point of Service (option for Medicare Advantage plan)

PPO – Preferred Provider Organization (type of Medicare Advantage plan)

PSO – Provider Sponsored Organization (type of Medicare Advantage plan)

QI – Qualified Individual program (MSP)

QIC – Qualified Independent Contractor (Maximus/CHDR)

QIO – Quality Improvement Organization (Lumetra)

QMB – Qualified Medicare Beneficiary program (MSP)

SEP – Special Enrollment Period

SLMB – Specified Low-Income Medicare Beneficiary program (MSP)

SNF – Skilled Nursing facility

SNP – Special Needs Plan (type of Medicare Advantage plan)

SOC – Share of cost (Medi-Cal program)

SSA – Social Security Administration

SSDI – Social Security Disability Insurance

SSI – Supplemental Security Income

TrOOP – True Out of Pocket Costs – Part D

URC – Utilization Review Committee

[This Page Intentionally Blank}